

907 KAR 1:145
Incorporation by Reference

Amendment after Comments

Supports for Community Living Manual, October 2007 edition

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COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:145, Supports for community living services for an individual with mental retardation or a developmental disability

Summary of Material Incorporated by Reference

Amendment after Comments

The "Supports for Community Living Manual, October 2007 edition" replaces the April 2007 Edition. Revisions include the following:

1. The addition of the "Medication Error Report", which is to be used by providers to report medication errors. The report is a two (2) page document.
2. The addition of the "SCL Screening and Training Requirements" which offers providers a snapshot view of trainer and trainee requirements all in one document to assist them with compliance. This is a two (2) page document.

The total number of pages incorporated by reference for this administrative regulation is 155 pages.

Commonwealth of Kentucky

Supports for Community Living Manual

October 2007 Edition

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care and Community Alternatives
Human Resources Building
275 East Main Street
Frankfort, KY 40621

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A. Support For Community Living Waiver Eligibility

1. An individual shall be eligible for SCL services under one of the following three (3) eligibility groups:
 - a. Mandatory categorically needy,
 - b. Optional categorically needy including an individual under a special income level, or
 - c. The medically needy.

This shall include the aged, persons with disabilities, and persons eligible under KTAP and related categories.

2. Treatment of Income and Resources of Target Population

- a. Financial eligibility determinations for the special income provision shall be made in the same manner as determinations are made for ICF/MR/DD Institutional deeming rules shall be applied.
- b. SCL Waiver members shall be allowed to retain, from their own income, an amount equal to the Supplemental Social Security Income (SSI) basic benefit rate plus the SSI general disregard for basic maintenance needs. If the SSI benefit rate or standard deduction changes, the allowable maintenance shall change accordingly.
- c. Patient liability for the month of admission shall be zero except in the following situations:

Community deeming rules for Medicaid eligibility shall be used for the month of admission for all SCL Waiver members who are married or under the age of eighteen (18). The income and resources of the spouse or parent shall be considered to be available for the month of admission only. For each succeeding month of SCL Waiver participation, only the income and resources of the SCL member shall determine Medicaid eligibility.
- d. The SCL Waiver member and/or legal representative shall be advised to apply for services at the local Department for Community Based Services (DCBS) office. The SCL Waiver member and/or legal representative shall indicate that the application is for eligibility under the special income category of the SCL Waiver program.
- e. The SCL member and/or legal representative shall be advised to contact the local DCBS office in the following situations:

- (1) The member's Medicaid eligibility was based upon a recent ICF/MR/DD

admission.

(2) The member's Medicaid eligibility was based on the "Spend-Down" category.

- f. The SCL members and/or legal representative shall notify the local DCBS worker of admission into the SCL waiver program to determine if further applications for Medicaid special income provision eligibility are required. If an SCL member is considered for eligibility based upon the special income criteria, the SCL provider shall follow normal SCL admission procedures.

3. Continuing Income Liability

Upon determination by the local DCBS office that a member has a continuing income liability, it shall be paid by the SCL member and/or legal representative to the SCL Residential provider. If there is not a Residential provider, it shall be paid by the SCL member and/or legal representative to the SCL Case Management provider. This amount shall be deducted monthly by the Department for Medicaid Services (DMS) from payments issued to the primary SCL provider. The SCL provider shall be notified of the amount of the continuing income liability on the form MAP- 552k (APPENDIX III). The SCL provider is responsible for collecting this money from the SCL Waiver member and/or legal representative. If the member chooses CDO then patient liability will be paid to the Support Broker.

B. Enrollment of an Individual into the SCL Waiver program

1. The individual shall meet the level of care for ICF/MR/DD services. This determination shall be made by the Quality Improvement Organization (QIO).
 - a. All initial and re-certification applications for SCL Waiver services shall first be determined to meet Medicaid criteria for the ICF/MR/DD level of care. This includes individuals currently in an ICF/MR/DD.
 - b. Level of care determinations shall be made at least every twelve (12) months. Individuals being re-certified for continued participation in the SCL waiver program will receive a level of care determination prior to the end of the certification period.
 - c. The Case Management provider will request a verbal level of care certification from the QIO three weeks (21 days) prior to the end of the current level of care certification; inform the QIO of the current dates at the time of the telephone call to ensure that the new certification period is consecutive; submit the MAP-351, assessment/reassessment and the MAP-109, Plan of Care to the QIO within twenty one days (21) days of receiving the verbal level of care certification. If all criteria are met, the

QIO shall evaluate the assessment/reassessment material and authorize continued level of care for the member and prior authorize the services requested on the MAP-109.

- d. Coverage shall not be available for any SCL waiver services during any period of time that an individual is not covered by a valid level of care determination. Both level of care and service prior authorizations shall be current for services to be Medicaid eligible.
 - e. The level of care determination is based upon information on the MAP-351 assessment form submitted to the QIO. Additional information may be requested by the QIO, such as a history and physical examination, psychological, functional analysis, and other service documentation included in the individual's record. After completion and approval of the level of care, the QIO shall send a written verification of the level of care determination to the Case Management provider.
 - f. If the ICF/MR/DD level of care is denied, the QIO shall send written notification to the SCL provider, the individual or legal representative, and DMHMR.
2. After obtaining the level of care determination, the Case Management provider shall assemble the application or recertification packet and forward it to the QIO if the member has chosen traditional services only, or make the referral to the Support Broker if the member chooses Consumer directed or blended services.
3. For traditional service delivery, upon receipt of the allocation letter from DMHMR, a Plan of Care shall be developed, utilizing the person centered planning process and guiding principles, by the individual and legal representative (if applicable), the Case Management provider designated by the individual or legal representative. The Plan of Care Shall:
- a. Include the individual's chosen personal goals,
 - b. Be developed and implemented within thirty (30) days of service initiation,
 - c. Be effective for the current level of care certification period,
 - d. Be individualized for each SCL member,
 - e. Designate a Case Manager for the SCL member,
 - f. Specify supports needed, the names and numbers of selected providers and the frequency and duration of services,
 - g. Include all pages of the Plan of Care,
 - h. MAP 109 will be updated as needed,
 - i. Be renewed annually.

4. The application or recertification packet shall be reviewed, and if approved by the QIO services, will be prior authorized. If the application is denied, written notification, including the appeals procedure shall be sent to the Case Management provider or Support Broker and the individual or legal representative. Upon receipt of a MAP-24C, the individual shall be placed in payment status. The date of placement indicated on the MAP-24C shall establish the effective date of initiation of payment for services.
5. The MAP-109, Plan of Care shall be submitted at least annually to the QIO. The entire Plan of Care shall be kept on file at the provider agency by the Case Manager. A minimum of twenty-five percent (25%) sample of Plan of Care shall be reviewed by the designated agency.
6. The entire Plan of Care shall be submitted to the QIO for any plan with a cost above the current average cost per person in the waiver. The justification for the need for the requested units of services, including copies of specific goals and objectives with personal outcomes for each service shall be included with the plan. If the service is new, the task objectives sheet should list the skills performance that will be recorded. For individuals who have been receiving the support, copies of staff notes documenting process toward the personal outcomes listed in the plan shall be submitted. The Plan of Care shall be sent to the QIO within fourteen (14) days of the effective date of the change. No approval of a Plan of Care shall be backdated. Justification for the requested units of service, including staff notes shall be submitted with the Plan of Care reflecting a cost above the current average cost per person in the waiver.
7. For individuals choosing consumer directed option or blended services, upon approval of the level of care and referral from the Case Manager, the Support Broker will assist the individual in development of the Plan of Care. The Plan of Care shall be developed utilizing the person centered planning process and guiding principles and specify the supports needed, names of selected providers and the frequency and duration of services. The MAP-109 shall be submitted to the QIO for prior authorization and approval of the individualized budget amount upon admission to the waiver and at least annually thereafter. The individualized budget will be authorized for a six (6) month period.

C. SCL Waiver Provider Enrollment and Certification

1. An entity wishing to enroll and participate as an SCL provider shall:
 - a. Request a participation packet from DMS or its designee,
 - b. Submit the completed packet to DMS or its designee, including a copy of the license if requesting participation as a group home as outlined in 902 KAR 20:078, and

- c. Notify DMS or its designee in writing regarding any change in program participation status (i.e. change of ownership, address changes, etc).
2. Upon receipt of a completed and acceptable enrollment packet by DMS or its designee, the DMHMR shall:
 - a. Conduct a pre-service survey, and
 - b. Recommend certification when DMHMR determines compliance with all applicable conditions of participation in this manual.
3. DMS shall:
 - a. Consider DMHMR's recommendation in the determination to grant certification,
 - b. Notify the provider in writing of their certification, and
 - c. Assign a Medicaid provider number with a prefix of thirty-three (33) to each certified SCL provider.
4. DMHMR shall:
 - a. Conduct a survey to determine compliance with SCL program requirements prior to recommending certification;
 - b. Request a plan of correction if deficiencies are noted (deficiencies that are neither corrected nor have a plan of correction within thirty (30) days of written notice may result in a recommendation to de-certify),
 - c. Recommend a certification if all requirements are met,
 - d. Conduct a follow-up survey within forty-five (45) days of initiation of services, and at least annually thereafter, and
 - e. Recommend de-certification of a provider at anytime if conditions of participation is not met.
5. If deficiencies are noted, the provider shall:
 - a. Develop an acceptable plan of correction in writing which:
 - (1) Specifically addresses methods to be utilized in making necessary corrections, and

(2) Specifies completion dates.

- b. Submit the written plan of correction to DMHMR within thirty (30) days of written notification of deficiencies.

6. DMS Shall:

- a. Issue an initial agreement for participation for six (6) months if all certification requirements are met, and
 - b. Terminate a provider agreement for participation based on non-compliance with applicable requirements or a recommendation for de-certification from the surveying agency.
7. During a termination process whether voluntary or involuntary, the provider shall fully cooperate with DMHMR, DMS and DCBS by allowing open access to the agency's records, including any and all records related to SCL members served by the SCL provider, any and all records pertaining to the operation of the SCL provider, and access to any residential site occupied by an SCL member.
8. For Consumer Directed Option, service providers shall complete a Kentucky Consumer Directed Option Employee/Provider Contract.

D. Covered Services

1. Adult Day Training:

- a. Procedure code T2021 with modifier HB for adult onsite service,
- b. Procedure code H2021 for off site service, and
- c. One (1) unit of service equals fifteen (15) minutes.

2. Adult Foster Care:

- a. Procedure code S5140, and
- b. One (1) unit of service equals twenty-four (24) hours.

3. Assessment/Reassessment

- a. Procedure code T1028

4. Behavior Support:

- a. Procedure code H0002 for a Functional Analysis,

- b. Procedure code H0032 for Developing the plan,
 - c. Procedure code H0004 for monitoring the plan, and
 - d. One (1) unit of service equals fifteen (15) minutes.
- 5. Case Management:
 - a. Procedure code T2022, and
 - b. One (1) unit of service equals one (1) month.
- 6. Children's day habilitation:
 - a. Procedure code T2021 with modifier HA, and
 - b. One (1) unit of service equals fifteen (15) minutes.
- 7. Community Living Supports:
 - a. Procedure code 97535, and
 - b. One (1) unit of service equals fifteen (15) minutes.
- 8. Family Home:
 - a. Procedure code H0043, and
 - b. One (1) unit of service equals twenty-four (24) hours.
- 9. Group Home:
 - a. Procedure code S5126, and
 - b. One (1) unit of service equals twenty-four (24) hours.
- 10. Occupational Therapy:
 - a. Procedure code 97530, and
 - b. One (1) unit of service equals fifteen (15) minutes.
- 11. Physical Therapy:

- a. Procedure code 97110, and
- b. One (1) unit of service equals fifteen (15) minutes.

12. Psychological Services:

- a. Procedure code 90804, and
- b. One (1) unit of service equals fifteen (15) minutes.

13. Respite:

- a. Procedure code T1005,
- b. Shall be billed as total number of units provided, and
- c. One (1) unit of service equals fifteen (15) minutes.

14. Specialized Medical equipment and Supplies:

- a. Procedure code E1399,
- b. One (1) unit of service equals one (1) item, service or treatment.
- c. The procedures regarding the Specialized Medical Equipment and

Supplies are as follows:

(1) The Case Manager or Support Broker shall complete the MAP-95 packet and submit it to the Department of Medicaid Services Division of Long Term Care, This packet shall include:

- (a) A completed MAP-95 (APPENDIX);
- (b) A signed Physician order or Prescription;
- (c) A detailed description of the product or service;
- (d) Not be available through the department's durable medical equipment, vision, hearing or dental programs. A copy of the denial may be requested.
- (e) Three (3) estimates for the product or service, except for dental.

(2) Verification of need of the equipment or service

identified in the Plan of Care;

- (3) Verification that the equipment or service is unavailable through the State Plan;
- (4) If unavailable through the State Plan, the request for Equipment or Vision will be reduced to the lowest of the three (3) submitted estimates. The request for Dental will be reduced by twenty percent (20%);
- (5) If available through the State Plan the MAP-95 will be rejected and the services or equipment will be purchased through the services offered in the State Plan;
- (6) If a completed request packet has been submitted and denied, the member has the right to appeal;
- (7) Upon approval, letters approving the item/service will be sent to the Case Manager; and
- (8) After the approved item has been purchased, the following shall be submitted for payment:
 - (1) A copy of the approval letters from DMS; and
 - (2) A copy of the MAP-95;
 - (3) A completed CMS 1500 using the procedure code E1399 for payment.
 - (4) The receipt for the item purchased.

15. Speech Therapy:

- a. Procedure Code 92507, and
- b. One (1) unit of service equals fifteen (15) minutes.

16. Staffed Residence:

- a. Procedure code T2016, and
- b. One (1) unit of service equals twenty-four (24) hours.

17. Supported Employment:

- a. Procedure code H0039, and
- b. One (1) unit of service equals fifteen (15) minutes.

E. Consumer Directed Option Services

1. Adult Day Training S5100 One (1) unit of service equals fifteen (15) minutes.
2. Community Living Supports S5108 One (1) unit of service equals fifteen (15) minutes.
3. Respite S5150 One (1) unit of service equals fifteen (15) minutes .
4. Supportive Employment H2023 One (1) unit of service equals fifteen (15) minutes.

F. North Carolina Support Needs Assessment Profile (NC-SNAP)

1. An initial NC-SNAP assessment shall be administered by DMHMR upon allocation of SCL funding.
2. DMHMR is responsible for the cost of all initial NC-SNAP assessments.
3. When an SCL provider requests a reassessment due to a change in the SCL member's need, the provider is responsible for the cost of the NC-SNAP reassessment. If an SCL provider feels a reassessment is necessary, the provider shall submit a written request to:

SCL Waiver Manager
Division of Mental Retardation
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621

4. The request for a reassessment shall include the SCL member's name and address of the SCL waiver provider making the request. Payment of \$100.00 must accompany a copy of the request for the reassessment and sent to the SCL Waiver Manager at DMHMR. The check or money order shall be made payable to the Kentucky State Treasurer.

G. North Carolina Support Needs Assessment Profile (NC-SNAP) Instructor's Manual

1. The NC-SNAP Instructor's Manual is used to teach the NC-SNAP Assessors.

H. North Carolina Support Needs Assessment Profile (NC-SNAP) Examiner's Guide

- 1. The NC-SNAP Examiner's Guide is used by the NC-SNAP examiner when conducting assessments.**

NC SNAP



NORTH CAROLINA

Support Needs Assessment Profile

EXAMINER'S
GUIDE

Murdoch Center Foundation
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Butner, North Carolina 27509
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Do not copy

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Background

The North Carolina Support Needs Assessment Profile (*NC-SNAP*) was developed in order to respond to a systemic need identified by the North Carolina Developmental Disabilities Policy Work Group in 1997. This system-wide need became apparent through Policy Work Group discussions pertaining to funding/cost, and consistent and accurate identification of people's needs for supports and services. The Policy Work Group established an Assessment Subcommittee whose task was to identify an assessment protocol that could be used system-wide to consistently and reliably assess a person's level of intensity of need for developmental disabilities (DD) supports and services. The Assessment Subcommittee (chaired by J. Michael Hennike) reviewed the available literature, the existing assessment tools, and the current assessment practices of other states. In doing so, it became apparent that no existing instrument would adequately address the requirements established by the DD Policy Work Group. Therefore, the Assessment Subcommittee directed the Murdoch Center Research Group and the Murdoch Center Foundation to pursue the development, research, and field-testing of an assessment instrument that would be a valid, reliable, and easy-to-use measure of a person's level or intensity of need for DD supports and services. The *NC-SNAP* is the result of 3 years and countless hours of work by many people in the service system.

Purpose

This Examiner's Guide is provided as an aid for examiners certified to administer the NC-SNAP. The NC-SNAP, when completed, will indicate the intensity or level of need in three important domains and provide an overall level of need for supports. The three domains are (1) Daily Living Supports, (2) Health Care Supports, and (3) Behavioral Supports. The levels range from 1 (low need) to 5 (extreme need) for each domain and for the overall score.

When administered properly, the NC-SNAP will provide a reliable, valid, and consistent method for determining needs for a person with developmental disabilities. It should function as a starting point for the development of a person-centered support plan. It will also provide a statewide database to assist in system planning, monitoring, and accountability. It should be noted, however, that the NC-SNAP is not a diagnostic tool, and it is not intended to replace any formal professional or diagnostic assessment instrument.

Certification of competency to use the NC-SNAP is a requirement.

General Layout

The NC-SNAP is divided into four pages. The first page is divided into three parts. Part I obtains general background information on the individual and examiner; Part II contains general instructions about scoring the NC-SNAP; and Part III provides a graphic profile summary for the completed NC-SNAP. The second page contains items for the Daily Living Supports Domain. Page three contains items for the Health Care Supports and Behavioral Supports Domains. Page four provides a grid for listing current needs, supports, and preferences, which may be useful in the development of a person-centered plan.

Preparation

The NC-SNAP must be completed by a certified examiner [generally a case manager or Qualified Developmental Disability Professional (QDDP)]. While the NC-SNAP can be completed in a very brief period of time, the examiner must be prepared with a thorough knowledge of the individual. Examiners who do not know the individual well should gather records and/or information from the individual or from someone who knows the individual well.

- *It is often useful to have the individual's records available while completing the NC-SNAP. Current evaluations such as psychosocial evaluations, nursing assessments, psychological evaluations, etc. and previous person-centered plans can be very helpful.*
- *Information from direct sources such as the individual, parents, guardians, or service or support providers can be helpful when completing the NC-SNAP.*
- *It is acceptable to use multiple sources to gather necessary information. If a discrepancy is noted in information provided by two different sources, the examiner should resolve the discrepancy through further discussion or by seeking additional information.*

Completing the NC - SNAP

Step I: Background Information

This section contains basic identification information regarding the person to be assessed, the examiner (person filling out the NC-SNAP), and the date of the assessment. There is also a data entry coversheet that should be filled out. This coversheet provides pertinent information for the statewide database. After completing these, the examiner proceeds to the Domain Checklists that begin on Page 2.

Step II: The Domain Checklists

There are three Domain Checklists: Daily Living Supports, Health Care Supports, and Behavioral Supports. Each domain lists support types in bold print along the top and level of intensity in bold print along the side. Level of intensity is ordered from "1" (minimum) to "5" (maximum). The boxes in the remainder of the grids list descriptions of the supports at various levels of intensity. Not all supports are divided into 5 levels. Wherever there is no description of a support at a given level, the corresponding box is shaded light blue.

The NC-SNAP is completed by reading the descriptions of the level of supports in each column from top down until the examiner identifies that description which best describes the individual's need for that support. The corresponding box is marked with an "X" and the examiner proceeds to the column for the next support until all three domains are completed.

In completing the Domain grids, it is important to focus on what the person needs, not on what the person has now, or on what he or she may need in addition to current supports. This should be done without comparison to other people's needs or supports. The fact that a person may be receiving more or less than he/she truly needs is irrelevant at this point.

The following section elaborates on the scoring criteria for the various supports in each domain.

Scoring Criteria

Daily Living Supports

Supervision:

Describes the number of hours daily that a support person must be available to assist the individual in daily living supports (e.g., self-care, activities of daily living) or to ensure safety. The critical distinction between levels 1, 2, and 3 is the number of 8-hour time periods that are required for supervision. More than 8 hours up to 16 hours describes level 2, while more than 16 hours describes levels 3, 4, or 5. Extreme need (Level 5) describes a person who requires specialized 24-hour supervision with continuous monitoring.

- *Note: Continuous monitoring means that the person supervising the individual must constantly monitor the individual.*
- *Note: Level 5 here and throughout the NC-SNAP refers to unusually extreme need. As such, Level 5 scores should be uncommon. Whereas Levels 1 through 4 represent steps along a continuum (such that Level 2 is applicable once the Level 1 description is exceeded, etc.), Level 5 represents needs that are substantially more intense than Level 4.*

Assistance Needed:

Three types of assistance are described:

Minimal assistance refers to the use of verbal prompts or gestures given at a critical point in the behavior sequence such as a reminder to brush teeth.

Partial assistance refers to the use of hands-on guidance for part of the task (for instance, helping a person turn on a water faucet), or completion of some part of the task (for instance, washing the person's legs because she/he cannot do it during a shower).

Complete assistance requires that a caregiver complete all parts of task, although a caregiver may get some partial assistance from the individual, such as the individual raising his or her arms during bathing.

Extreme need (Level 5) is distinguished by the absence of any form of participation by the individual in any task.

This section also distinguishes four types of skills: self-help (e.g., handwashing, eating), daily living (e.g., cooking, cleaning), decision making (e.g., planning activities, making purchases), and complex skills (e.g., financial planning, health planning). Note that the descriptions of both the type of assistance required and the type of skills completed change across levels.

Persons who can independently complete some tasks within a skill area (e.g., drink from cup, remove coat, etc.) should be scored at Level 3. A person who needs help with all tasks should be scored at Level 4.

Age - Related:

Score this column according to the individual's chronological age.

Degree of Structure Provided by Others:

This refers to that set of skills needed to plan and carry out daily activities. At Level 1, assistance is required only for special activities (e.g., vacation). At Level 3, the person's daily activities must be both planned and initiated by another person.

Some examiners find it helpful to view this support area in the context of a "day off." On a typical day off, does the individual arise independently and follow his or her own schedule for the day? (Level 1) Or does someone else have to help him or her decide what to do and when to do it? (Level 2) Or does someone else have to plan the day's schedule and prompt the individual to perform each scheduled activity? (Level 3)

Health Care Supports

Physician Services:

Levels 2-5 describe people with chronic health care needs beyond routine physical checks and monitoring (e.g., seizure disorder, diabetes, hypertension). If representative of current needs, consider the individual's health for the past year and average his or her physician visits on a quarterly basis.

Note: Level 5 applies only to individuals with extreme needs requiring that a physician be available immediately (i.e., close proximity to the person; this does not refer to on-call or emergency-room physicians) and for frequent monitoring.

Nursing Services:

Refers to activities of an RN or LPN. *Reminder:* Consider only those activities that a nurse must do. Sometimes nurses are readily available due to the type of residential setting. When determining whether the individual has nursing needs, reflect on whether the nurse would have to be present for the service to occur. If the service can be provided by someone else if the nurse isn't available the need is not a *nursing* service.

Allied Health Professionals:

Refers to services needed from a Speech Therapist, Physical Therapist, Occupational Therapist, and/or another licensed health service provider other than a mental health service provider. Score Level 1 if the individual needs to see the professional less often than once per week (or not at all).

Equipment Supports:

Refers to adaptive equipment prescribed by health services providers (e.g., wheelchairs, communication devices). To score Level 2, the person's equipment should require frequent repair, service, or replacement (once a month or more often). The actual purchase of the equipment (regardless of cost) is not relevant in scoring this item. Level 1 should also be scored if there are no equipment support needs.

Behavioral Supports

Mental Health Services:

Level 1 services, if any, are those provided by any mental health service provider which are directed toward a temporary or acute condition (e.g., grief counseling following the loss of a loved one). Level 2 consultation can be provided by any mental health services provider and results in ongoing intervention. Levels 3 - 5 require a formal behavior intervention plan developed by a psychologist. The complexity of the plan and the experience of the psychologist developing it increase from Level 3 to Level 5.

Behavioral Severity:

Describes the threat of injury to self and/or others, which does or may occur. Level 5 applies only to those for whom a special environment is necessitated by the severity of behavior. Note that "life threatening" refers to behavior that poses an immediate threat of death or severe injury (e.g., severe head banging, extreme aggression, suicidal behavior, etc.).

Direct Intervention:

Describes the extent of staff support required specifically for behavioral intervention. It also describes the intensity of such intervention. The use of restraint [immobilization of body part(s)] is categorized either on a continuous basis (Level 3) or contingent upon (i.e., following) a target behavior (Level 4). The use of preventive intervention techniques is also described at two levels: standard procedures (Level 3) and specialized procedures (Level 4). Any intervention that requires at minimum 24-hour one-to-one staffing is defined at Level 5.

Step III: NC-SNAP Profile

After scoring each item in each domain, complete the NC-SNAP Profile on page 1. The grid in this section corresponds to the three domain grids completed in Step II. Where an "X" had been placed in the domain grid, a circle is now placed in the profile grid. Thus, to fill out the chart, find the level (from 1 to 5) which you scored for each item, beginning with the Daily Living Domain. Circle the corresponding number on the chart on page 1. Continue this process for the Health Care and Behavioral Domains.

- *Note: It is important to do this process carefully to avoid errors that could affect the final score!*

Then, for each domain, connect the circles with a line, as illustrated below.

Daily Living Domain				Health Care Domain				Behavior Domain		
Superv	Assist	Age	Struct	MD	RN	Allie	Equi	MH	Severly	Intervc
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5

Next, follow the instructions to record the highest score for each domain in the appropriate box under the chart. ["Highest" refers to numerical values; therefore, 5 is the highest possible score, 1 is the lowest.]

Example:

Daily Living Supports = 3
Health Care Supports = 2
Behavioral Supports = 4

Then, in the box labeled "Overall Level of Eligible Support," enter the highest of the three scores from the boxes above.

This is the consumer's final NC-SNAP score.

Example:

Overall Level of Eligible Support = 4

Finally, complete the Cumulative Score Section.

- The Domain Cumulative Score is determined by adding the highest score in each of the three domains (i.e., the scores in the three boxes below the profile grid). This is the sum of the domain high scores.
- The Cumulative Raw Score is determined by adding all 11 scores; that is, the score for each item in each domain. This is the sum of scores.

Example:

Cumulative Score (add all scores)

A. Domain Scores (range = 3 to 15) = 9
(Sum of the highest levels in each domain)

B. Raw Scores (range = 11 to 46) = 27
(Sum of all levels in all domains)

Step IV : NC-SNAP Support Grid (optional)

Notes

The NC-SNAP Support Grid is an optional tool that may assist in the planning for providing needed services and supports. It is completed for each item in each domain. The first column identifies the need established in completing the support grid. Current Natural Supports and Current Services are next identified (Columns 2 and 3). From this description, the planner next establishes if there is an existing unmet need (Column 4). Finally, the preferred manner of meeting the need is identified in Column 5. An example is provided on the NC-SNAP form.

Conclusion

The NC-SNAP will be administered for each consumer in, or on the waiting list for, the state's Developmental Disabilities Service System:

- *When an individual enters the DD Service System*
- *Annually*
- *Whenever there is a significant change in the individual's need profile*

Congratulations! You have now completed this Examiner's Guide. Keep this guide for future reference. Thanks for taking the time to learn about the NC-SNAP. When it comes to assessing supports and needs for persons with developmental disabilities, remember: **The first step is a "SNAP"!**

North Carolina Support Needs Assessment Profile (NC-SNAP)

INSTRUCTIONS: Complete the background information below. Then, using the Domain grids on Pages 2 and 3, start at the top of each column and read down until you locate the level that best describes the individual's current needs. When you find that level, make an "X" in the box. Then proceed to the next column. Repeat the process for each grid. After completing all three grids, proceed to Section II, the "NC-SNAP Profile" below.

Note: Focus only on this particular person's needs. Do not make comparisons to other individuals. Also, do not base your answers solely on what services the individual is or is not receiving; focus on what supports the individual truly needs. For example, the individual may reside in a setting that provides 24-hour staff coverage; consider whether this level of support is actually needed for the individual or if less supervision would be appropriate.

I. Background Information

Individual's Name: _____
 Social Security No.: _____
 Unique ID No.: _____ Case No.: _____
 Birthdate: _____ Age: _____
 Address: _____
 Phone: (____) _____
 County: _____ Area Program: _____
 Are There Significant Natural Supports in Place? Yes No
 Current DD System Supports: (Check only one)
 ___ First Contact ___ Waiting List (no services)
 ___ In Service ___ Waiting List (insufficient services)
 Examiner: _____ Phone: (____) _____
 NC-SNAP Certification No.: _____
 (relationship to individual: _____)
 Date of Assessment: _____

II. NC-SNAP Profile

After completing all three grids:

- find the level marked for each column on Pages 2 and 3 and circle that level in the corresponding column of the chart below.
- draw a line connecting the circles in each domain on the chart below.
- record the highest score for each domain in the appropriate box below.
- write the highest of these three scores in the "Overall Level of Eligible Support" box.
- then, proceed to Page 4, the NC-SNAP Support Summary.

Daily Living Domain				Health Care Domain				Behavioral Domain		
Support	Assist	Age	Superv	ML	RN	Albed	Equip	MLL	Severity	Interven
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5

Daily Living Supports = _____

Health Care Supports = _____

Behavioral Supports = _____

Overall Level of Eligible Support = _____

Do not copy

North Carolina Support Needs Assessment Profile (NC-SNAP)

Daily Living Supports

Level	Supervision	Assistance Needed	Age-Related	Degree of Structure Provided by Others
1	Less than 8 hours per day on average	<ul style="list-style-type: none"> No assistance needed in most self-help and daily living areas Minimal assistance needed in some self-help and daily living areas Minimal to complete assistance needed to complete complex skills such as financial planning and health planning 	Adult (16.01 years and above)	None or Minimal <ul style="list-style-type: none"> Few special activities need to be planned for the person
2	9-16 hours daily on average	<ul style="list-style-type: none"> No assistance in some self-help, daily living areas Minimal assistance for many skills Complete assistance needed in some basic skills and all complex skills 	Child/Teen (6.01 to 16 years)	Moderate to Extreme <ul style="list-style-type: none"> Some or all daily activities need to be planned for the person
3	24 hours (does not require awake person overnight)	<ul style="list-style-type: none"> Partial (hands on assistance) to complete assistance needed in most areas of self-help, daily living, and decision making Cannot complete complex skills 	Young Child (2.01 to 6 years)	Intensive <ul style="list-style-type: none"> All activities must be planned and initiated for the person
4	24 hours with awake person overnight	<ul style="list-style-type: none"> Partial to complete assistance is needed in all areas of self-help, daily living, decision making, and complex skills 	Infant (Birth to 2 years)	
5	Extreme Need: 24 hours, awake person trained to meet individual's particular needs; continuous monitoring	<ul style="list-style-type: none"> Extreme Need: All tasks must be done for the individual, with no participation from the individual 		

North Carolina Support Needs Assessment Profile (NC-SNAP)

Health Care Supports

Level	Physician Services	Nursing Services	Allied Health Professionals	Equipment Supports
1	For routine health care only	For routine health care only	Less often than once per week	Less often than once per month
2	Up to quarterly consultation or treatment for chronic health care need	1 -- 3 times per month	One or more times per week	One or more times per month
3		Weekly		
4	More than quarterly for consultation or treatment	Daily		
5	Extreme Need: Chronic medical condition requires immediate availability and frequent monitoring	Extreme Need: Several times daily or continuous availability		

Behavioral Supports

Mental Health Services	Behavioral Severity	Direct intervention
None or Periodic e.g., counseling, motivation or self-help programs	• None	• None
Consultation e.g., to develop and/or monitor individualized guidelines or reinforcement procedures plus counseling if needed	• Not injurious to self and/or others -but- • Mildly disruptive	• Intervention necessary using routine techniques (e.g., interruption of behavior and redirection) • May require individualized staffing on a part-time basis
Consultation by licensed or certified mental health professional • to develop and/or monitor a formal behavior intervention program	• Injurious to self and/or others -or- • Severely disruptive	• Application of protective interventions which may be restraining
Treatment by licensed or certified MH professional with expertise in the treatment of extreme behavior problems • comprehensive intervention plan based on analysis, frequent assessment, and structuring of interactions • direct oversight of plan by licensed professional	• Life threatening	• Application of contingent interventions which may be restraining -or- • Individualized preventive intervention techniques
Extreme Need: Treatment by specialized professional team (with advanced experience with extreme behavior problems) • daily contact • 24 hour on call • complex intervention plan providing continuous assessment and refinement	• Extreme Need: Severity of behavior requires controlled environment which prohibits unauthorized leaving	• Extreme Need: Intervention procedures require continuous 24-hour 1:1 or greater staffing

North Carolina Support Needs Assessment Profile (NC-SNAP)

III. NC-SNAP Support Summary

Use this grid to summarize the results of this NC-SNAP. List the support needs that were identified, as well as any supports or services that are currently in place to meet these needs. Indicate "Yes" if there is an unmet need. Also note individual or family preferences for particular supports. [See example below.] This information should be helpful to the planning team as it prepares to develop the person's support plan.

EXAMPLE

Daily Living Domain: Supervision: 24-hour awake staff	Parents	Aide, 2 hr/wk	Assistive Living Apartment with 24-hour aide
--	---------	---------------	--

Needs	Current Natural Supports	Other Current Supports	Need Is Unmet	Preferences or Requested Supports
<u>Daily Living Domain:</u>				
Supervision:				
Assistance:				
Age-Related:				
Structure:				
<u>Health Care Domain:</u>				
Physician (MD):				
Nursing:				
Allied Prof.:				
Equipment:				
<u>Behavioral Domain:</u>				
Mental Health:				
Severity:				
Intervention:				
<u>Other: (e.g., vocation, communication)</u>				

NORTH CAROLINA
Support Needs Assessment Profile



NC-SNAP

Instructor's
Manual

"Do not copy"

Acknowledgments

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J Michael Hemmke, Alexander M Myers,
Rodney E. Realon, and Thomas J Thompson

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Chapter 1:

Examiner's Guide

Background

The North Carolina Support Needs Assessment Profile (NC-SNAP) was developed in order to respond to a systemic need identified by the North Carolina Developmental Disabilities Policy Work Group in 1997. This system-wide need became apparent through Policy Work Group discussions pertaining to funding/cost, and consistent and accurate identification of people's needs for supports and services. The Policy Work Group established an Assessment Subcommittee whose task was to identify an assessment protocol that could be used system-wide to consistently and reliably assess a person's level of intensity of need for developmental disabilities (DD) supports and services. The Assessment Subcommittee (chaired by J. Michael Hennike) reviewed the available literature, the existing assessment tools, and the current assessment practices of other states. In doing so, it became apparent that no existing instrument would adequately address the requirements established by the DD Policy Work Group. Therefore, the Assessment Subcommittee directed the Murdoch Center Research Group and the Murdoch Center Foundation to pursue the development, research, and field-testing of an assessment instrument that would be a valid, reliable, and easy-to-use measure of a person's level or intensity of need for DD supports and services. The NC-SNAP is the result of 3 years and countless hours of work by many people in the service system.

The authors are grateful for the cooperation of 2,927 persons in the service system and their guardians and families. We are appreciative of the support from 200 case managers and numerous providers throughout the state who assisted with the research and field test.

Purpose

This Examiner's Guide is provided as an aid for examiners certified to administer the *NC-SNAP*. The *NC-SNAP*, when completed, will indicate the intensity or level of need in three important domains and provide an overall level of need for supports. The three domains are (1) Daily Living Supports, (2) Health Care Supports, and (3) Behavioral Supports. The levels range from 1 (low need) to 5 (extreme need) in each domain and for the overall score.

When administered properly, the *NC-SNAP* will provide a reliable, valid, and consistent method for determining needs for a person with developmental disabilities. It should function as a starting point for the development of a person-centered support plan. It will also provide a statewide database to assist in system planning, monitoring, and accountability. It should be noted, however, that the *NC-SNAP* is not a diagnostic tool, and it is not intended to replace any formal professional or diagnostic assessment instrument.

Certification of competency to use the *NC-SNAP* is a requirement.

General Layout

The NC-SNAP is divided into four pages. The first page is divided into three parts. Part I obtains general background information on the individual and examiner; Part II contains general instructions about scoring the NC-SNAP; and Part III provides a graphic profile summary for the completed NC-SNAP. The second page contains items for the Daily Living Supports Domain. Page three contains items for the Health Care Supports and Behavioral Supports Domains. Page four provides a grid for listing current needs, supports, and preferences, which may be useful in the development of a person-centered plan.

Preparation

The NC-SNAP must be completed by a certified examiner [generally a case manager or Qualified Developmental Disabilities Professional (QDDP)]. While the NC-SNAP can be completed in a very brief period of time, the examiner must be prepared with a thorough knowledge of the individual. Examiners who do not know the individual well should gather records and/or information from the individual or from someone who knows the individual well.

- ~~It is often useful to have the individual's records available while completing the NC-SNAP. Current evaluations such as psychosocial evaluations, nursing assessments, psychological evaluations, etc, and previous person-centered plans can be very helpful.~~
- Information from direct sources such as the individual, parents, guardians, or service or support providers can be helpful when completing the NC-SNAP.

- *It is acceptable to use multiple sources to gather necessary information. If a discrepancy is noted in information provided by two different sources, the examiner should resolve the discrepancy through further discussion or by seeking additional information.*

Completing the NC - SNAP

Step I: Background Information

This section contains basic identification information regarding the person to be assessed, the examiner (person filling out the NC-SNAP), and the date of the assessment. There is also a data entry coversheet that should be filled out. This coversheet provides pertinent information for the statewide database. After completing these, the examiner proceeds to the Domain Checklists that begin on Page 2.

Step II: The Domain Checklists

There are three Domain Checklists: Daily Living Supports, Health Care Supports, and Behavioral Supports. Each domain lists support types in bold print along the top and level of intensity in bold print along the side. Level of intensity is ordered from "1" (minimum) to "5" (maximum). The boxes in the remainder of the grids list descriptions of the supports at various levels of intensity. Not all supports are divided into 5 levels. Wherever there is no description of a support at a given level, the corresponding box is shaded light blue.

The AC-SMAP is completed by reading the descriptions of the level of supports in each column from top down until the examiner identifies that description which best describes the individual's need for that support. The corresponding box is marked with an "X" and the examiner proceeds to the column for the next support until all three domains are completed.

In completing the Domain grids, it is important to focus on what the person needs, not on what the person has now or on what he or she may need in addition to current supports. This should be done without comparison to other people's needs or supports. The fact that a person may be receiving more or less than he/she truly needs is irrelevant at this point.

The following section elaborates on the scoring criteria for the various supports in each domain.

Scoring Criteria

Daily Living Supports

Supervision:

Describes the number of hours daily that a support person must be available to assist the individual in daily living supports (e.g., self-care, activities of daily living) or to ensure safety. The critical distinction between levels 1, 2, and 3 is the number of 8-hour time periods that are required for supervision. More than 8 hours up to 16 hours describes level 2, while more than 16 hours describes levels 3, 4, or 5. Extreme need (Level 5) describes a person who requires specialized 24-hour supervision with continuous monitoring.

- *Note: Continuous monitoring means that the person supervising the individual must constantly monitor the individual.*
- *Note: Level 5 here and throughout the NC-SNAP refers to unusually extreme need. As such, Level 5 scores should be uncommon. Whereas Levels 1 through 4 represent steps along a continuum (such that Level 2 is applicable once the Level 1 description is exceeded, etc.). Level 5 represents needs that are substantially more intense than Level 4.*

Assistance Needed:

Three types of assistance are described:

Minimal assistance refers to the use of verbal prompts or gestures given at a critical point in the behavior sequence such as a reminder to brush teeth.

Partial assistance refers to the use of hands-on guidance for part of the task (for instance, helping a person turn on a water faucet), or completion of some part of the task (for instance, washing the person's legs because she/he cannot do it during a shower).

Complete assistance requires that a caregiver complete all parts of task, although a caregiver may get some partial assistance from the individual, such as the individual raising his or her arms during bathing.

Extreme need (Level 5) is distinguished by the absence of any form of participation by the individual in any task.

This section also distinguishes four types of skills: self-help (e.g., handwashing, eating), daily living (e.g., cooking, cleaning), decision making (e.g., planning activities, making purchases), and complex skills (e.g., financial planning, health planning). Note that the descriptions of both the type of assistance required and the type of skills completed change across levels.

Persons who can independently complete some tasks within a skill area (e.g., drink from cup, removing coat, etc.) should be scored at Level 3. ~~A person who needs help with all tasks~~ should be scored at Level 4.

Age - Related:

Score this column according to the individual's chronological age.

Degree of Structure Provided by Others:

This refers to that set of skills needed to plan and carry out daily activities. At Level 1, assistance is required only for special activities (e.g., vacation). At Level 3, the person's daily activities must be both planned and initiated by another person.

Some examiners find it helpful to view this support area in the context of a "day off." On a typical day off, does the individual arise independently and follow his or her own schedule for the day?(Level 1) Or does someone else have to help him/her decide what to do and when to do it?(Level 2) Or does someone else have to plan the day's schedule and prompt the individual to perform each scheduled activity?(Level 3)

Health Care Supports

Physician Services:

Levels 2-5 describe people with chronic health care needs beyond routine physical checks and monitoring (e.g., seizure disorder, diabetes, hypertension). ~~If representative of current~~ needs, consider the individual's health for the past year and average his or her physician visits on a quarterly basis.

Note: Level 5 applies only to individuals with extreme needs requiring that a physician be available immediately (i.e., close proximity to the person; this does not refer to on-call or emergency-room physicians) and for frequent monitoring.

Nursing Services:

Refers to activities of an RN or LPN. *Reminder:* Consider only those activities that a nurse must do. Sometimes nurses are readily available due to the type of residential setting. When determining whether the individual has nursing needs, reflect on whether the nurse would have to be present for the service to occur. If the service can be provided by someone else if the nurse isn't available the need is not a *nursing* service.

Allied Health Professionals:

Refers to services needed from a Speech Therapist, Physical Therapist, Occupational Therapist, and/or another licensed health service provider other than a mental health service provider. Score Level 1 if the individual needs to see the professional less often than once per week (or not at all).

Equipment Supports:

Refers to adaptive equipment prescribed by health services providers (e.g., wheelchairs; communication devices). To score Level 2, the person's equipment should require frequent repair, service, or replacement (once a month or more often). The actual purchase of the equipment (regardless of cost) is not relevant in scoring this item. Level 1 should also be scored if there are no equipment support needs.

Behavioral Supports

Mental Health Services:

Level 1 services, if any, are those provided by any mental health service provider which are directed toward a temporary or acute

condition (e.g., grief counseling following the loss of a loved one). Level 2 consultation can be provided by any mental health service provider and results in ongoing intervention. Levels 3 - 5 require a formal behavior intervention plan developed by a psychologist. The complexity of the plan and the experience of the psychologist developing it increase from Level 3 to Level 5.

Behavioral Severity:

Describes the threat of injury to self and/or others, which does or may occur. Level 5 applies only to those for whom a special environment is necessitated by the severity of behavior. Note that "life threatening" refers to behavior that poses an immediate threat of death or severe injury (e.g., severe head banging, extreme aggression, suicidal behavior, etc.)

Direct Intervention:

Describes the extent of staff support required specifically for behavioral intervention. It also describes the intensity of such intervention. The use of restraint [immobilization of body part(s)] is categorized either on a continuous basis (Level 3) or contingent upon (i.e., following) a target behavior (Level 4). The use of preventive intervention techniques is also described at two levels: standard procedures (Level 3) and specialized procedures (Level 4). Any intervention that requires at minimum 24-hour one-to-one staffing is defined at Level 5.

Step III: NC-SNAP Profile

After scoring each item in each domain, complete the NC-SNAP Profile on page one. The grid in this section corresponds to the three domain grids completed in Step II. Where an "X" had been placed in the domain grid, a circle is now placed in the profile grid. Thus, to fill out the chart, find the level (from 1 to 5) which you scored for each item, beginning with the Daily Living Domain. Circle the corresponding number on the chart on page 1. Continue this process for the Health Care and Behavioral Domains.

- *Note It is important to do this process carefully to avoid errors that could affect the final score!*

Then, for each domain, connect the circles with a line, as illustrated below.

Daily Living Domain				Health Care Domain				Behavior Domain		
Super	Assist	Age	Struct	MD	RN	Allied	Equip	MH	Severity	Interve
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5

Next, follow the instructions to record the highest score for each domain in the appropriate box under the chart. ['Highest' refers to numerical values; therefore, 5 is the highest possible score. 1 is the lowest.]

Example:

Daily Living Supports = 3

Health Care Supports = 2

Behavioral Supports = 4

Then, in the box labeled "Overall Level of Eligible Support," enter the highest of the three scores from the boxes above. *This is the individual's final NC-SNAP score.*

Example:

Overall Level of Eligible Support = 4

Finally, complete the Cumulative Score Section

- A. The Domain Cumulative Score is determined by adding the highest score in each of the three domains (i.e., the scores in the three boxes below the profile grid). This is the sum of the domain high scores
- B. The Cumulative Raw Score is determined by adding all 11 scores; that is, the score for each item in each domain. This is the sum of scores

Example:

Cumulative Score (add all scores)

A. Domain Scores (range = 3 to 15) = 9
(Sum of the highest levels in each domain)

B. Raw Scores (range = 11 to 46) = 27
(Sum of all levels in all domains)

Step IV (optional): *NC-SNAP* Support Grid

The *NC-SNAP* Support Grid is an optional tool that may assist in the planning for providing needed services and supports. It is completed for each item in each domain. The first column identifies the need established in completing the support grid. Current Natural Supports and Current Services are next identified (Columns 2 and 3). From this description, the planner next establishes if there is an existing unmet need (Column 4). Finally, the preferred manner of meeting the need is identified in Column 5. An example is provided on the *NC-SNAP* form.

Conclusion

The *NC-SNAP* will be administered for each person in, or on the waiting list for, the state's Developmental Disabilities Service System:

- When an individual enters the DD Service System
- Annually
- Whenever there is a significant change in the individual's need profile

Congratulations! You have now completed this Examiner's Guide. Keep this guide for future reference. Thanks for taking the time to learn about the *NC-SNAP*. When it comes to assessing supports and needs for persons with developmental disabilities, remember: The first step is a "SNAP"!

Chapter 2:

Guidelines for *NC-SNAP* Instructors

Introduction – Teaching others to administer the *NC-SNAP* is not a difficult task. It does, however, require preparation and attention to detail. Once you have been certified as an instructor by attending training offered by the *NC-SNAP* authors, you may teach others. The following outline will assist you in completing this task.

Setting – Training should occur in a well-lit, classroom-style setting where participants have access to a desktop for writing and reviewing records.

Class Size – A maximum of 20 students, with 2 certified instructors.

Materials – A copy of the *NC-SNAP*, the *NC-SNAP* Examiner's Guide, "Sample Case History #1," and "Sample Case History #2" should be available for each participant. Instructors should have a ready supply of "Sample Case History #3" in case of need. The instructor will also need a good quality television and VCR to show the *NC-SNAP* videotape.

Time – Allow 2 hours for training. In many cases the actual time will be less. You must allow adequate time for checking the accuracy of each participant's work and completing the certification process.

Preparation – Instructors should prepare by reviewing the *NC-SNAP* and this Instructor's Manual.

Points to Emphasize:

- The *NC-SNAP* is a brief assessment tool used to determine individual needs in three domains: Daily Living Supports, Health Care Supports, and Behavioral Supports. Items in each domain are scored on a five-level scale. The examiner then completes a brief scoring profile. An optional support summary is available for use in assisting in the development of a plan for support.
 - The *NC-SNAP* is not designed to replace standardized assessment instruments typically administered by professional support staff (such as cognitive and adaptive psychological evaluations, physical exams, speech and hearing evaluations, etc.)
 - The *NC-SNAP* can be helpful in determining an individual plan of supports and services. Aggregate data can also be used by area and state authorities for monitoring and planning.
 - Data from the *NC-SNAP* can be entered into a statewide database. Thus a state or region can have a current comprehensive database for citizens with developmental disabilities.
-
- The *NC-SNAP* is to be completed annually, and whenever there is a significant change in an individual's need profile, for each person who is served, or on a waiting list to be served, by the Developmental Disabilities Service System.

Training Instructions:

Students in the class must successfully complete two *NC-SNAP* assessments using standardized case histories known as "Sample Case History #1" and "Sample Case History #2." The first case will be completed during the video presentation. Allow time for students to read "Sample Case History #1" before starting the video. When the video program instructs you to pause, the students should be given time to complete the indicated portion of the instrument. As they do this, the instructor should walk around the classroom, answering questions as students fill out the *NC-SNAP*. Students should be encouraged to avoid "working ahead" of the videotape as this inevitably results in errors.

- At the completion of the video, the first *NC-SNAP* assessment should be completed. Instructors should verify that all students obtained the correct "Overall Level of Eligible Support" score. Then, the instructors should review the three (Daily Living, Health Care, and Behavioral Supports) Domain Scores. It is not necessary to review the grid responses item by item; one of the strengths of the *NC-SNAP* is that occasional scoring variations can occur without affecting the overall result. It is important that students arrive at the correct Domain Scores. When a student's Domain Score is not correct, review the item(s) which caused the discrepancy and correct them (suggestion: it is often helpful to ask other students who got the correct Domain Score to explain why they marked the correct score).

Next, the instructors should present the second case history to the students. The students should then complete the second

NC-SNAP assessment using the information provided. The instructors should allow students to complete this NC-SNAP assessment independently; questions may be answered, but care should be taken to avoid helping the students fill out the form.

If the student completes this second NC-SNAP correctly (i.e., attains correct scores for the "Overall Level of Eligible Support" and the three Domain Scores), the instructor may proceed with certification (See Chapter 3). If not, the student should be offered corrective feedback and then given a third standardized case history ("Sample Case History #3") as a retest. To be certified, the trainee must complete one of these last two NC-SNAP assessments correctly. If the student does not meet this criterion, he/she should be scheduled to attend another training class."

▪ *Note 1: The three sample case histories are included at the end of this chapter. Each contains all the information needed to complete the NC-SNAP. Students should be cautioned that these are abbreviated summaries. Advise them not to speculate about needs or infer needs that are not specified.*

▪ *Note 2: Distribute the first case at the start of class. Distribute the second case after the video is concluded.*

▪ *Note 3: A completed NC-SNAP Profile is also included for each sample case. Remember: When reviewing the students' completed NC-SNAPs, it is not necessary to proceed item-to-item. Instead, verify that all students obtain the correct Overall Level of Eligible Support score and*

then review the three (Daily Living, Health Care, and Behavioral Supports) Domain scores. The individual column scores are presented here as an aid for instructors.

- Note 4: Caution: This information must be kept from distribution to preserve integrity of the NC-SNAP.
- Note 5: Suggestion: Students should be discouraged from discussing or sharing answers before the instructors review the results.
- Note 6: Students who arrive late for class generally should be rescheduled for another class if they arrive following the first pause in the videotape, unless an instructor is available to work directly with the students to catch them up.

NC-SNAP Examiner Training

SAMPLE CASE HISTORY #1

Name:	Alex Smith	Unique ID:	SMIA022952
Birthdate:	2-29-52	Soc Sec. No.:	987-65-4321
Address:	123 Uphill Drive	Area Program:	Crossroads
	Anytown, USA 27600	County:	Wake
Phone:	(919) 555-1212		
Date of Single Portal Review:	7-14-99		

Alex is a male Caucasian diagnosed with Down Syndrome, moderate mental retardation, moderate bilateral hearing loss, and epilepsy. He has had no seizures for the past 3 years and he takes depakote for seizure control. He is monitored quarterly by his physician. Nursing services are required for routine health care only. Alex wears hearing aids which he can care for independently and visits his audiologist for semi-annual checks.

Alex lives in a supervised apartment with assistance from staff during waking hours (6:30 AM to 10 PM). He requires no supervision at night. Alex requires no assistance in some self-help and daily-living areas (dressing, grooming, and dining). He needs verbal prompting to wash and fold his clothes, bathe thoroughly, and complete general household cleaning duties (e.g., mop, vacuum, clean windows). He requires complete assistance in preparing meals, shopping, shaving, nail care, and financial management (i.e., paying bills).

For the past 15 years, Alex has been employed 7 hours per day in a state-funded sheltered workshop. At the workshop, he assembles small items, earning about \$20 per week. Alex can plan some simple activities such as watching TV, sitting on the porch greeting passersby or creating abstract paintings in watercolor. However, Alex requires assistance planning some daily activities such as shopping for clothes, purchasing toiletries or art supplies, medical appointments, or any leisure or recreational activities away from the

home. Alex understands that it is unsafe to allow strangers into the home and he knows how to notify 911 in an emergency, using a programmed telephone.

Alex occasionally has difficulty getting along with co-workers. Apparently, because of his impaired hearing, co-workers will taunt him from time-to-time. When this happens, Alex will become upset, yelling at his co-workers and threatening them (but never actually physically striking anyone). Following behavioral consultation from a regional resource, his vocational instructors began following interruption/redirection guidelines developed for Alex. Also in place is a simple reinforcement procedure to enhance appropriate social interactions.

Sample Case History # 1: Alex

Instructor's Scoring Profile

Daily Living Domain				Health Care Domain				Behavior Domain		
Superv	Assist	Med	Struct	MD	Phy	Mind	Emot	MH	Severity	Interven
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5

Daily Living Supports = 2

Health Care Supports = 2

Behavioral Supports = 2

Overall Level of Eligible Support = 2

Cumulative Score (add all scores)

- A. Domain Scores (range = 3 to 15) = 6
 (Sum of the highest levels in each domain)
- B. Raw Scores (range = 11 to 46) = 18
 (Sum of all levels in all domains)

NC-SNAP Examiner Training

SAMPLE CASE HISTORY #2

Name: Megan Jones

Unique ID: JONM101680

Birthdate: 10-16-80

Soc. Sec. No.: 012-34-5678

Address: Route 75, Box 101

Area Program: Foothills

Sometown, USA

County: Burke

Phone: (828) 555-1212

Date of Single Portal Review: 9-1-99

Megan is a female African-American. Her history indicates normal development as an infant until she contracted an encephalitis infection. As a result, she experienced severe developmental consequences including poor motor development and speech delay. Megan can ambulate only short distances with a very awkward gait. She typically uses a walker if ambulating more than a few feet. Megan is seen semi-annually by a physical therapist to assess her range of motion and to maintain her walker. She communicates by making noises to indicate displeasure and smiles to indicate pleasure. She has generalized tonic-clonic seizures that are treated with the use of dilantin, phenobarbital and tegretol. She has averaged about three seizures per month for the past year. As a result, she is seen monthly by her primary physician and approximately twice a year by a neurologist.

Megan is diagnosed as having profound mental retardation. In 1990 her parents were no longer able to care for her at home. After review by the Single Portal Coordinator, it was determined that Megan would best be served in a state-run ICF-MR group home which is designed to assist persons with severe behavioral needs. Megan requires hands-on assistance in most daily living activities. While she can not complete complex skills, she can perform some self-help and daily-living tasks with verbal prompting. Megan requires 24-hour supervision, with monitoring by staff at night every 30-to-60 minutes.

Megan must be prompted to engage in all daily activities by group home staff. She is unable to plan these activities for herself. During weekdays, she attends an Adult Day Activity Support where she participates in leisure and recreational activities.

Megan exhibits severe arm biting behavior that typically involves breaking the skin. The behavior occurs about 5 times per month and typically is treated with topical antibacterial ointment and bandages under a nurse's supervision. At any given time, Megan typically has several abraded areas on her arms; these are slow to heal. As a result, her arms are checked and treated daily by a nurse. A behavior intervention plan is in place for this behavior. It was written and is monitored and assessed regularly by a psychologist who specializes in the treatment of severe self-injury. The psychologist has direct oversight of this plan and its implementation. Megan receives frequent positive reinforcement for adaptive behaviors. When she bites her arm, she is treated medically if needed and then placed in contingent restraint devices until she is calm, up to one hour per application.

Sample Case History # 2: Megan

Instructor's Scoring Profile

Daily Living Domain				Health Care Domain				Behavior Domain		
Superv	Assist	Med	Struct	MD	RN	Alld	Equip	MH	Severity	Interven
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5

Daily Living Supports = 4

Health Care Supports = 4

Behavioral Supports = 4

Overall Level of Eligible Support = 4

Cumulative Score (add all scores)

C. Domain Scores (range = 3 to 15) = 12
 (Sum of the highest levels in each domain)

D. Raw Scores (range = 11 to 46) = 32
 (Sum of all levels in all domains)

NC-SNAP Examiner Training

SAMPLE CASE HISTORY #3

Name:	Tom Miller	Unique ID:	MILT030663
Birthdate:	3-6-63	Soc Sec. No.:	234-56-7890
Address:	44 Swiss Street	Area Program:	Pathways
	Alpine, USA 27509	County:	Granville
Phone:	(999) 555-1212		
Date of Single Portal Review:	6-30-99		

Tom lives in the Infirmary of Western Casberry Center, a state Mental Retardation Center. Tom has many physical disabilities including diagnoses of major motor seizures, severe spastic quadriplegia, microcephaly, Type I diabetes, contractures, and scoliosis. Due to respiratory difficulties, Tom breathes with the aid of a ventilator; this requires continuous medical monitoring. Tom's motor movements consist only of side-to-side head rolling that occurs without apparent relationship to environmental events. He is totally dependent on staff for complete assistance in all aspects of daily living. He receives nutrition by gastrostomy tube. His medical condition requires the use of extensive equipment for the purposes of monitoring his status and responding to medical emergencies. This equipment is essential, remains in Tom's presence at all times, and is serviced frequently (at times daily) to ensure continuous operation. ~~Due to Tom's extensive medical needs, staff receives training to~~ provide his individualized care; part of this care involves continuous 24-hour monitoring of his health status.

Over the past three months, Tom has had four episodes of seizures requiring injection of medication to stop the seizures. Due to his "brittle" diabetes, Tom's glucose level is monitored regularly and adjusted as necessary through nutrition or insulin injections. For these reasons, a nurse must be continuously available for medical treatment, and a physician must be immediately available for emergency situations and frequent monitoring. Tom is seen semiannually by a physical therapist to assess his need for supportive devices including splints to prevent contractures. Maintenance of his specialized wheelchair is ongoing. In order to accommodate his special needs, the wheelchair is inspected weekly and frequent adjustments are made. When his health permits, Tom is taken to sensory stimulation activities on his living unit. Tom has been diagnosed as having profound mental retardation. He exhibits no significant adaptive or maladaptive behavior. All grooming and hygiene activities are completed by staff.

Sample Case History # 3: Tom

Instructor's Scoring Profile

Daily Living Domain				Health Care Domain				Behavior Domain		
Superv	Assist	Transf	Struct	MD	RN	Ther	Equip	MH	Severity	Integrtn
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5

Daily Living Supports = 5

Health Care Supports = 5

Behavioral Supports = 1

Overall Level of Eligible Support = 5

Cumulative Score (add all scores)

E Domain Scores (range = 3 to 15) = 11
 (Sum of the highest levels in each domain)

F Raw Scores (range = 11 to 46) = 30
 (Sum of all levels in all domains)

Chapter 3

Certification

- Only Certified Examiners may administer the *NC-SNAP*.
- Only Certified Instructors may teach others to become certified examiners.
- Only *NC-SNAP* Authors may certify Instructors.
- Each Certified Examiner will be given a certification number at the time he or she successfully completes the class. The certification number itself will consist of the year, the regional code, and a number. Numbers should be given out sequentially. If desired, instructors may tell newly certified examiners their numbers so that they may immediately begin administering the *NC-SNAP*.
- Each Certified Instructor will also receive a certification number. These will be given out by the *NC-SNAP* Authors.
- Names and certification numbers of examiners and instructors should be entered into the database programs immediately following certification. The *NC-SNAP* Researchers will process this information promptly to ensure Certification Cards are mailed out in a timely manner. *Note:* This examiner information must be entered into the instructors' database at the MRC and into the Area Program's database. The database programs must contain this information before *NC-SNAP* data can be entered.

- Once awarded a certification number, a Certified Examiner may administer the *NC-SNAP* anywhere in the state.

- Certification Codes:

MRC Staff Development

Murdoch = MC

Caswell = CA

O'Berry = OB

Western Carolina Center = WC

Black Mountain = BM

MRC Outreach

North Central = NC

Eastern = EA

South Central = SC

Western = WE

Mountain = MT

- Re-certification is felt to be unnecessary at this time.

Chapter 4:

Data Entry (Statewide Database)

I. Program Installation

- *Note: Users who had installed the first (unnumbered) version of the NC-SNAP database program and are preparing to install Version 1.1 should first "Uninstall" the original program. To do this, go to "Control Panel," double-click on "Add/Remove Programs," select "NCSNAP," and follow instruction to remove the entire program.*

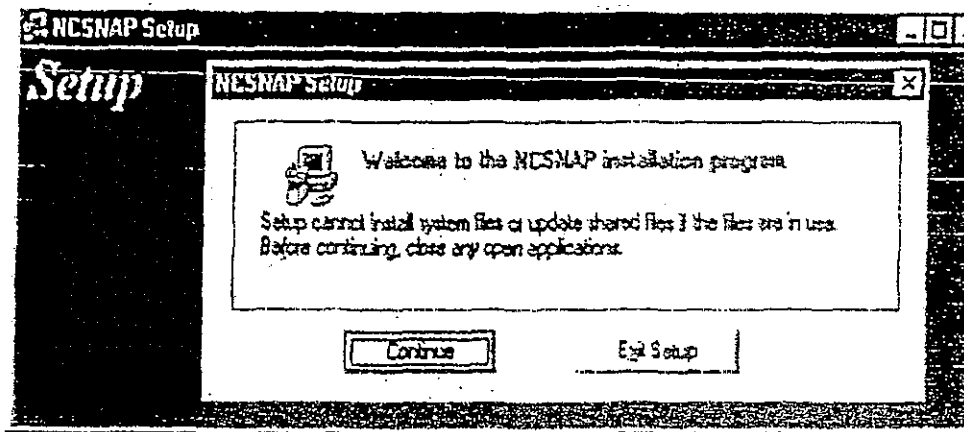
The NC-SNAP Database CD contains an installation program for the statewide database. The installation process consists of four steps, which must be performed in the sequence described below. The first two steps install two Microsoft Windows® components; the third step loads the NC-SNAP program; the fourth step closes the installation program.

- *Note: The database program is written in Microsoft Access®, and requires Microsoft Windows 95® or 98®. Prior to loading the Installation CD, determine which version of Microsoft Windows® your computer system runs. If you are unsure, find out by going to "Control Panel" and double click on "System."*
- *Note: Before beginning installation, close all running programs on your computer.*
- *At the close of this chapter, there is additional technical information about installation and licensing issues.*

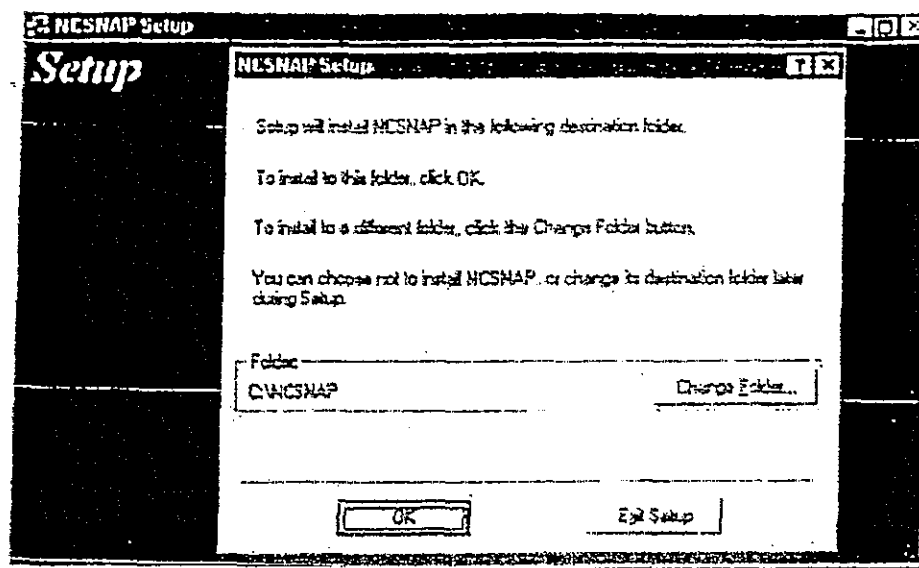
- A: Insert the CD in the CD drive and wait. The installation program should self-start. If it does not (be sure to give it enough time, some systems are slower than others), double click on "My Computer" on the Desktop; then double click on the CD drive and the program will start.
- B: Step 1: Windows 95[®] users ONLY (Windows 98[®] users skip to Section E): Press the button for Step 1. This installs an updated version of Microsoft DCOM95.
- C: Restart your computer. Usually you will be instructed to restart your computer, and this should occur automatically after a prompt. If it does not (i.e., you are returned to the Installation Menu without a prompt to restart the computer), press "Start," "Shut Down," select "Restart the computer?," and "Yes." Do not proceed without restarting your computer.
- D: After your computer restarts, double click on "My Computer" and then double click on the CD drive. This will return you to the Installation Menu.
- E: Step 2: All Users: Press the button for Step 2. This installs an updated version of Microsoft MDAC.
- F: Restart your computer. Usually you will be instructed to restart your computer, and this should occur automatically after a prompt. If it does not (i.e., you are returned to the Installation Menu without a

prompt to restart the computer). press "Start," "Shut Down," select "Restart the computer?," and "Yes." Do not proceed without restarting your computer.

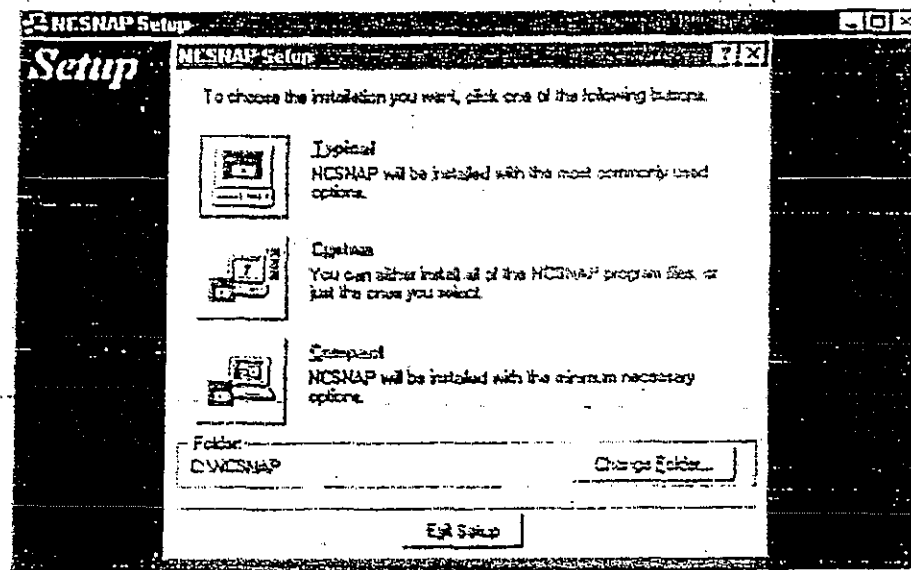
- **G: Step 3: All Users:** Press the button for Step 3. This installs the *NC-SNAP* software program. You should see the following screen:



- Click "Continue." Then click "OK" on the next screen to use the default location. [This path can be changed but we recommend that you do not do this unless absolutely necessary.]



- On the next screen, click the "Typical" button to install all components.



[Note to Computer Support: If you want to exclude a certain component (e.g., an ISAM), you can click the "custom" button and uncheck the component you do not want to install. However, you must install the program (NCSNAP) and the ODBC Support for SQL Server for the program to work.]

- The Setup program will copy files to your computer and set up necessary system files for the program. When it finishes you should see the message:

"NCSNAP Setup was completed successfully."

- Click "OK." The installation of the NCSNAP program is complete.
- Depending on your operating system, you may see a message confirming an addition to the system registry. Answer "Yes" and then "OK" when you see the message that the information has been added to the registry.
- H: Step 4: After the program is loaded and you return to the installation menu, press Step 4 "Close/Exit."
- I: Restart your computer. Usually you will be instructed to restart your computer, and this should occur automatically after a prompt. If it does not (i.e., you are returned to the Installation Menu without a prompt to restart the computer), press "Start," "Shut Down," select "Restart the computer?," and "Yes." Do not proceed without restarting your computer.

--You Are Now Ready to Use the Program!--

II. Instructions for Database Coversheet

Once you have completed a *NC-SNAP* assessment you will need to complete the Database Coversheet. This should only take you a few minutes. However, *you must record all of this information so that the data entry person can enter the NC-SNAP profile into the computer.* There is only one entry on this form that is optional: *Consumer Case #* (this does not apply to everybody). All other information must be completed.

Note that for the question "Are there significant natural supports in place?," 'significant' refers to natural supports that if no longer available would still have to be provided. E.g. if an individual lives at home with his or her parents, and the parents became incapacitated, would new supports be a necessity? If yes, circle "yes" on the coversheet. A reduced copy of a completed coversheet is included in this chapter. Note that this coversheet may be updated from time to time.

*North Carolina
Support Needs Assessment Profile
(NC-SNAP)*

Database Coversheet

When administering the NC-SNAP, complete all sections of this form. Please print neatly! When finished, staple this form to the NC-SNAP and then turn it in to your designated data-entry person.

Individual's Name: Miller, Tom Social Security No.: 234-56-7890
Individual's Unique ID No.: MILT030663 Individual's Case #: 467890
Examiner's Name: Aleck Myers NC-SNAP Certification No.: 99YK9910
Area Program: VGFW Is Area Program a provider of services? Yes ☒
County: Granville Are there significant natural supports in place? Yes ☒

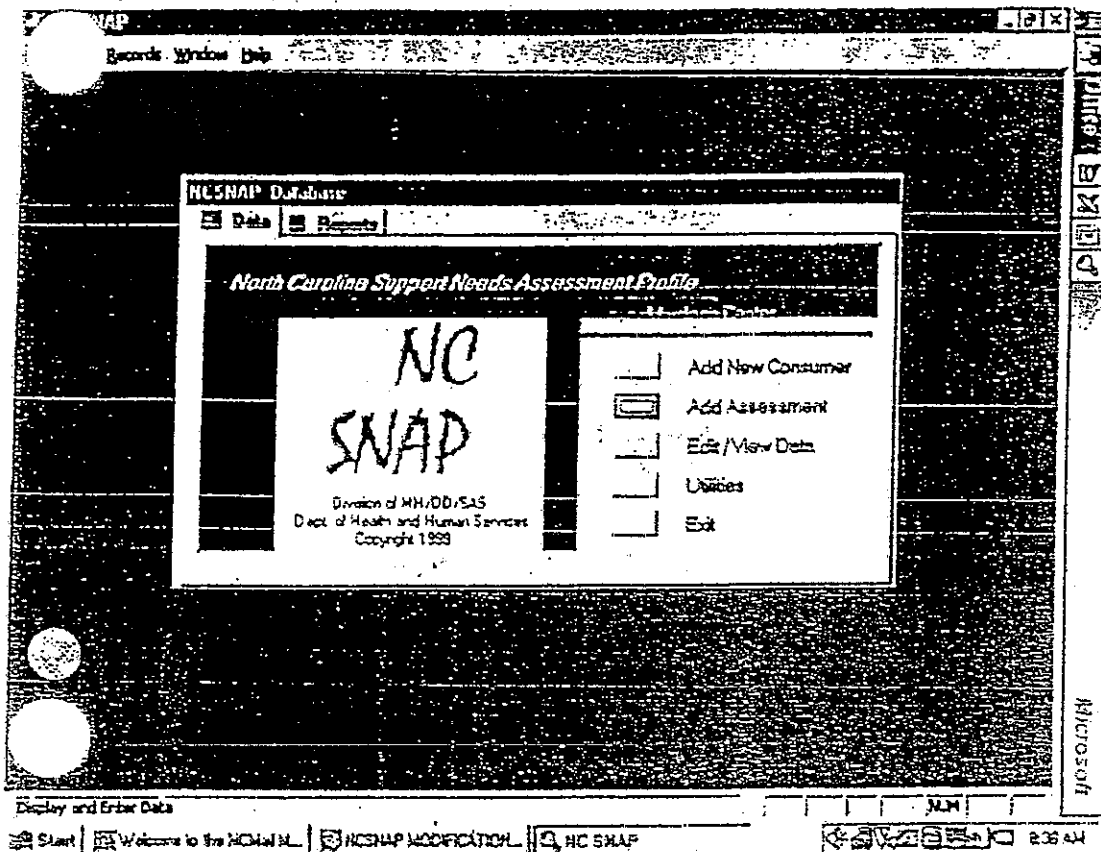
Individual's Type of Residential Placement: (Check only one)

- | | |
|---|--|
| <input type="checkbox"/> Independent Living | Group Home: |
| <input checked="" type="checkbox"/> Family Home | <input type="checkbox"/> DDA |
| <input type="checkbox"/> Foster Home | <input type="checkbox"/> ICF (Specify: |
| <input type="checkbox"/> Nursing/Rest Home | <input type="checkbox"/> State |
| <input type="checkbox"/> Skilled Nursing Home | <input type="checkbox"/> RHA |
| Supervised Living: | <input type="checkbox"/> VOLA |
| <input type="checkbox"/> EduCare | <input type="checkbox"/> EduCare |
| <input type="checkbox"/> RHA | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other (Specify: _____) | <input type="checkbox"/> (Specify: _____) |
| Alternative Family Living: | <input type="checkbox"/> MRBD |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Other (Specify: _____) |
| <input type="checkbox"/> Other | Mental Retardation Center |
| <input type="checkbox"/> Other Resid. Placement | <input type="checkbox"/> Black Mountain Center |
| <input type="checkbox"/> (Specify: _____) | <input type="checkbox"/> Caswell Center |
| | <input type="checkbox"/> Murdoch Center |
| | <input type="checkbox"/> O'Berry Center |
| | <input type="checkbox"/> Western Carolina Center |

Current DD System Support: (Check only one)

- ☐ This is first contact
☒ Waiting list (no services)
☐ Waiting list (insufficient supports)
☐ Just entering system (supports started)
☐ Services ext. & ongoing: (mark all that apply):
- | | |
|-----------------------------------|--------------------------------|
| <input type="checkbox"/> CAP | <input type="checkbox"/> TBI |
| <input type="checkbox"/> TANF | <input type="checkbox"/> CBI |
| <input type="checkbox"/> State | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medicaid | |

III. Instructions for Data Entry



The following section describes the step-by-step instructions for entering completed NC-SNAP's using the *NC-SNAP Statewide Database Program* software. Notice that the main menu has a folder tab at the top, "Data." This is where new or re-administration NC-SNAP's will be entered, where you can edit or update information and you can find utilities for setting up your computer system and entering certified examiner information. The second folder tab, "Reports," is where you can obtain reports on data that you have entered using the NC-SNAP software. "Reports" is also the tab you use to transmit your entered data to the statewide server.

There are nine functions that are described in this chapter:

- A. Initial Set-up
- B. Entering Newly Certified Examiners
- C. Entering a New *NC-SNAP* Consumer
- D. Entering an Additional Administration of the *NC-SNAP* for an Existing Consumer
- E. Editing/Viewing Data
- F. Generating Reports
- G. Instructor Class Preparation Report
- H. Sending Data to the Data Managers
- I. Other

A. Initial Set-up

The first time you enter the NCSNAP program, you will need to enter the following information. Note: You will only do this the first time.

File/Menu Program/Agency Information

Please enter your Agency Name and other program configuration data.
Click Save when ready.

Agency Name

Murdoch Center

☒ Is Service Provider

Data File Path

c:\ncsnap

DD Report Path

c:\ncsnap

Save

Cancel

- Enter your Agency Name (you can select from the menu by moving the cursor to the arrow symbol and pressing the left mouse button).
- Indicate whether your agency is a service provider, i.e., does the area program provide direct services in addition to case management? To indicate "Yes," place the cursor over the blank square and click the left mouse button.
- Enter the file path where you want the *NC-SNAP* software and *NC-SNAP* database. *A default path has been provided and we recommend that you use the default path provided. This path can be changed but we recommend that you do not do this unless absolutely necessary.*

Once you have entered this information, place the cursor over the button and press the left mouse key.

B. Entering Newly Certified Examiners

The names and certification numbers of certified examiners need to be entered into the database before a *NC-SNAP* profile can be entered. You can do this by going to the Main Menu (Data folder) and pressing the button. Press the button when you see the following screen:

Once you have completed entering examiner information, put your cursor over the ☒ button (this is in the upper right hand section of your window) and press your left mouse key to exit this screen.

Note: An examiner must be entered in this section first before you can enter in a NC-SNAP completed by that examiner.


Note: Each Area Program must enter this information for their certified examiners. After classes are completed, Instructors should ensure that MRC Outreach enters this information into its database and then forward on to each Area Program a list containing this information for their certified examiners.

C. Entering a New NC-SNAP Consumer

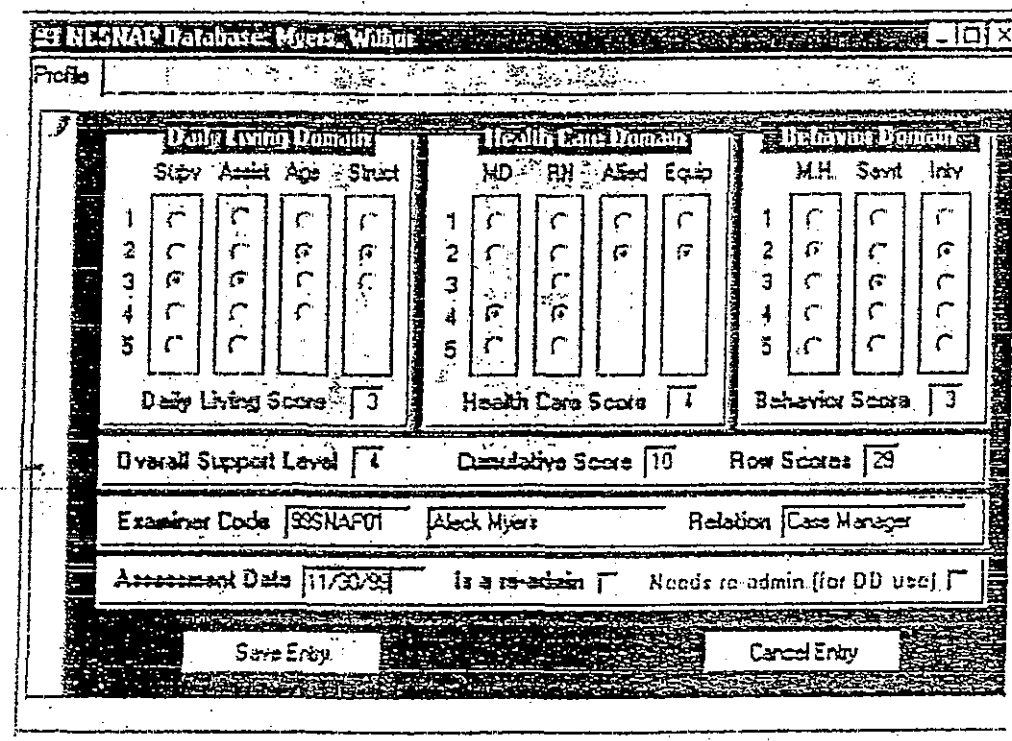
To enter an individual's NC-SNAP data for the first time, press the **Add New Consumer** button at the Main Menu.

The screenshot shows a software window titled "NC-SNAP Database" with a "Consumer Data" tab. The form contains the following fields and controls:

- Unique ID, Case No., and SSN (text input fields)
- Area Prog. (dropdown menu, currently showing "Murdoch Center") and Is a Service Provider (checkbox)
- Last Name, F. Name, and M.I. (text input fields)
- DOB (text input field) and Age (text input field)
- Address (text input field)
- City (text input field), State (dropdown menu, currently showing "NC"), and Zip (text input field)
- County (dropdown menu) and Phone (text input field)
- Res. Placement (dropdown menu)
- DD Support (dropdown menu)
- Case Reviewed by Single Portal Coordinator (dropdown menu, currently showing "No") and Last Assignment Date (text input field)
- Buttons at the bottom: "Enter Assessment", "This is for a condition", and "Cancel Entry".

Using the *NC-SNAP* Database Coversheet and page one of the *NC-SNAP*, complete the Consumer Data form on the computer screen. You must enter all of the information before you are allowed to proceed to the assessment data [the only exceptions are "Case No." and "M.I." (middle initial) which are optional but should be entered if available]. Use the drop down menus by pressing the down arrow  to complete the Area Program, County, Residential Placement, and DD Support information:

Once you enter the information, place the cursor over the Enter Assessment button and press the left mouse button. You should now see the Profile page:



Daily Living Domain				Health Care Domain				Behavior Domain		
Stdy	Assist	Age	Struct	MD	RN	Assd	Equip	M.H.	Sevnt	Intv
1				1				1		
2				2				2		
3				3				3		
4				4				4		
5				5				5		
Daily Living Score: <input type="text" value="3"/>				Health Care Score: <input type="text" value="1"/>				Behavior Score: <input type="text" value="3"/>		
Overall Support Level: <input type="text" value="4"/>				Cumulative Score: <input type="text" value="10"/>				Row Scores: <input type="text" value="29"/>		
Examiner Code: <input type="text" value="98SNAP01"/>				Examiner Name: <input type="text" value="Alec Myers"/>				Relation: <input type="text" value="Case Manager"/>		
Assessment Date: <input type="text" value="11/30/99"/>				Is a re-admin: <input type="checkbox"/>				Needs re-admin (for DD use): <input type="checkbox"/>		
<input type="button" value="Save Entry"/>				<input type="button" value="Cancel Entry"/>						

- To enter the assessment profile data place the cursor over the button in each column that corresponds with the scores marked on the *NC-SNAP* page one Profile and press the left mouse key.
- You must enter the Examiner Code, Relation, and Date of Assessment. Indicate if the *NC-SNAP* you are entering is a re-administration (i.e., scheduled as part of the Look-Behind Quality Assurance procedure--See Chapter 6). Once you have done this, put the cursor over the **Save Entry** button on the bottom of the form and press the left mouse button.
- If at any time you make an error or simply want to get out of this screen without saving your work, put the cursor over the **Cancel** button and press the left mouse key

D. Entering an Additional Administration of the *NC-SNAP* for an Existing Consumer

To enter new *NC-SNAP* data for an individual who already has data in the database, press the Add Assessment button at the Main Menu.

Add Assessment button

- This enables you to enter new *NC-SNAP* data (a subsequent assessment) without having to re-enter all of the consumer information.

- First, select the appropriate record from the list of existing entries. Note that this list can be sorted by selecting the desired column and then pressing up-or-down-arrow button on the toolbar to the right. This makes finding the record much easier.
- After selecting the appropriate record, press the "Enter Assessment" button
- Finally, enter the NC-SNAP profile information.
- Note that you will have to enter the examiner's number.
- After entering the profile information, go to "Edit/View Data" (see below) to ensure that the Consumer Data is still accurate (revise as needed if changes have occurred since the last entry).

E. Editing/Viewing Data

To view existing consumer information and profiles, or to edit information, press the Edit/View Data button at the Main Menu.

In this section you will be able to view and/or edit consumer information or *NC-SNAP* profile data.

-
- To do this, press the Edit/View Data button.
 - You will see a list of consumers to choose from.
 - Select the person whose information you wish to view or edit. Note that this list can be sorted by selecting the desired column and then pressing up-or-down-arrow button on the toolbar to the right. This makes finding the record much easier.

- Press the **Consumer Data** button.
- You can make changes by simply entering in the corrections.

To view the *NC-SNAP* profile for this person, press the **Assessments** button. You should now see a list of all *NC-SNAP* profiles saved for this person.

- Select the assessment date your wish to view or edit.
- Press the **Assessment Profile** button.
- You can make changes by simply entering in the corrections
- Press the **Consumer List** or **Consumer Data** button.
- Next press the **Main Menu** button to return to the Main Menu.

Note: These procedures can only be applied to revisions to current (untransmitted) information. After submission to the database server, NC-SNAP data can only be changed by the NC-SNAP researchers (contact Aleck Myers).

F. Generating Reports

~~To retrieve information on individuals from your agency entered~~
 into your local database, go back to the Main Menu and select the folder tab marked "*Reports*." You can retrieve a report on all of your data by going to the section *Select a Report*.

NCSNAP Database

Data Reports

NCSNAP Reports

Select a Report

Define Data Range

Statewide ☒ Region

Area Program

County

Age From To

Assess Date From To

Examiner

Overall Levels ☒ 1 ☒ 2 ☒ 3 ☒ 4 ☒ 5

Need re-admin ☒ Check re-admin ☒

Reports included are:

- 1 Consumer List: a complete listing of all persons entered
- 2 Age Group: a complete listing of all consumers by age groups (0 - 1, 2 - 6, 7 - 15, 16 - ___) and their corresponding scores
- 3 County: a complete listing of consumers and their overall scores by county
- 4 Overall Levels: a complete listing of all consumers and their overall scores
- 5 ~~Re-Admin: a listing of cases selected for NC-SNAP re-administration.~~
- 6 Class Sheet: a pre-class list that can be printed to facilitate assignment of certification numbers. (See Section G)
- 7 DD Report: this is where an area program submits the data they have entered to the DD Section Data must be submitted monthly. (See Section H)

If you would like to specify certain criteria prior to generating your report, you may do so by entering the criteria in the Define Data Range section. You can complete only one section or you may complete any combination of sections to limit your report. Below is a description of each section:

- 1 Assess. Date: you can enter a start date and end date to limit the number of records.
 - 2 Age: you can specify a particular age range (0-1, 2-6, 7-15, 16-__).
 - 3 County: allows you to limit your report to a certain county of responsibility
 - 4 Examiner: allows you to limit your report to a specific examiner
 - 5 Overall Levels: allows you to limit your report to a specific level(s).
- Note: To clear criteria from the screen, press the **Refresh** button.

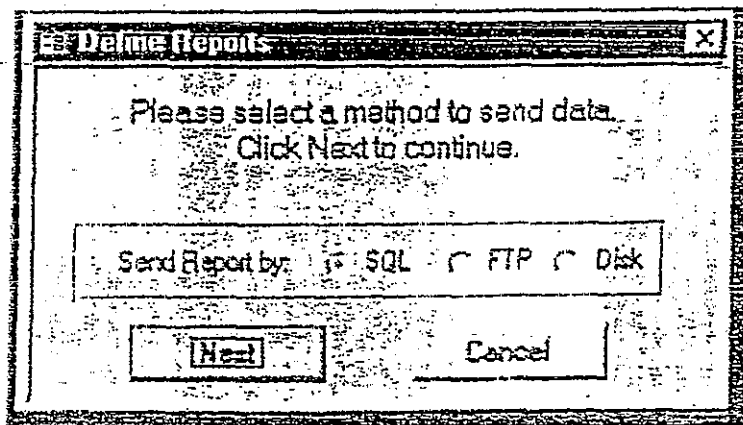
G. Instructor Class Preparation Report

To print a pre-class listing of unused certification numbers on a class sign-up sheet, select the "Instructor Class Preparation Report Form" from the Main Menu. After students sign up on this form, and successfully pass the course, you may verbally tell them their certification number and then enter their name and number into the database (see Section II above). [NOTE: The NC-SNAP authors will mail instructors the Examiners' Certification Cards within 2 weeks of data transmission.]

H. Sending Data to the Data Managers

- *Note: Transmit data only once each day. Repeat same-day transmissions are hard on the server. If for some reason a transmission attempt fails, you can continue to try to send data the same day.*
- *Note: If you attempt to send data via SQL or FTP but are unable to for some reason, continue trying that day. However, if you are still unable to accomplish this by the end of the day, save the data to a diskette that can be mailed in. [Once the attempt is made, your local computer will treat the data as sent and will not transmit the data the next day. This should rarely be a problem, but the data diskette will need to be mailed to Raleigh (see address below) for the server to acquire the data.]*

After finishing the data entry, return to the main menu. Select the "Report" tab. Under "Select a Report," select "DD Report." Then select one of the three options in the "Define Reports" window.



- *Note: Always select "SQL" (unless the option is unavailable). This option allows data to be transmitted directly to the statewide server.*
- If "SQL" is not an option (i.e., your internet connection does not permit it), select "*FTP*." This option will allow you to send a data file to Raleigh, where it will be stored until a staff member downloads it into the statewide server.
- Use the "*Disk*" option only when neither the "SQL" nor the "FTP" options are operational (e.g., you have no internet access). This option will download your data file to a floppy disk, which you must mail to Raleigh at the end of each calendar month (we recommend that you keep a backup diskette). The staff member in Raleigh will then download the data file into the server. If you must use this option, mail the diskette to :

Vannia Cotti, DD Section
3006 Mail Service Center
Raleigh, NC 27699-3006

- The SQL and FTP options both specify a URL. The URL is the address where the data reports are sent. Do not change it unless you receive a notice from the central office in Raleigh.

- For all these options, the "login ID" is ncsnapuser (all lowercase). For the "password" use ncsnap2000 (all lowercase).
- Whichever method of data transfer is used, a confirmation window will pop up to notify you that your records were successfully transferred.

I. Other

1. Individual's Unique ID No.: If unknown, this may be created by listing the first three letters of the person's last name, then the person's first initial, and then a six-digit number representing the person's birth date (2 digits for month, 2 digits for day, 2 digits for year). E.g., Tom Miller, born March 6, 1963 = MILT030663. If more than one person has an identical ID, the program will prompt the addition of a letter at the end of the ID (e.g., MILT030663A for Tom's twin sister Teri).
2. If you run into problems, contact one of these persons:
Aleck Myers (919) 575-7742 aleck.myers@ncmail.net
Rod Realon (919) 575-7913 rod.realon@ncmail.net
3. For program technical support, contact:
Han Di (919) 733-4460 han.di@ncmail.net

4. About Installation:

System Requirements:

Microsoft Windows 95® or 98®, Pentium 200 MHz or better CPU with 32 MB of memory recommended. An internet connection is needed for the program to send data to the central database directly. If you do not have an internet connection, you will need to store your data on a 3.5" diskette and mail it in monthly.

Microsoft Access97® is not required to run the NCSNAP program. The Setup program installs an Access97® Runtime version program for NCSNAP to operate. However, you can run NCSNAP directly on Access97® without using the Runtime version.

Troubleshooting:

Although the program and installation procedures have been tested repeatedly on different computers, errors may still occur. The most likely cause of errors in installation is that the DLL or OCX files in your Windows system are not compatible with the ones used or copied to your computer by the Setup program. If an error should occur during installation, please write down the entire error message and ask your system administrator for help. A very helpful source of information is the Microsoft Support Knowledge Base on the Microsoft webpage at the following location: <http://support.microsoft.com/support/kb>.

File Locations:

NCSNAP contains three Access97® database files:

- NCSNAP.MDE – This is the main program file.
- NCSNAP_DATA.MDB – This is the main user's data file including consumer, examiner, and assessment data.
- NCSNAP_REF.MDB – This file contains all reference data such as area program codes, county codes, and so on.

These files can be located on a local hard drive (e.g., C:) or on a network drive and shared. However, it is best to load the NCSNAP.MDE file on a local drive to reduce network traffic and improve performance. If more than one user and computer needs to access the program, the last two files can be copied to a network location and shared. The location of the data

file can be set on the "Utilities/Agency Info" screen within the program. You can use long file names for the data file path.

NCSNAP also needs a file location for creating report files to be sent to the central office in Raleigh. This location is set on the "Utilities/Agency Info" screen as "DD Report Path." It can be the same as the data file path or be at a different location. However, due to the limitation on internet FTP connection and the program component used in NCSNAP, the file path cannot contain spaces between words. For example, "My Documents" will not be acceptable but "MyNCSNAPReports" will be.

Networking Issues:

The NCSNAP program can be installed on a local area network to be shared among multiple users.

1. Install all three components (DCOM95 – for Windows 95® only, MDAC, and NCSNAP) on users' computers. NCSNAP should be installed on the C:\ drive.
2. Copy NCSNAP_DATA.MDB and NCSNAP_REF.MDB from one computer to a network location to be shared. Give all users necessary rights to this area.
3. On each user's computer, run NCSNAP. Select Utilities/Agency Info. Enter the network location where the shared NCSNAP data files are located in the Data Path box. Restart the program.

Licensing Issues:

DCOM95: This component is required by Microsoft MDAC which is required by NCSNAP. DCOM95 extends the support for Distributed Component Object Model (DCOM) for Microsoft Windows 95®. Its licensing agreement can be found on the Microsoft web site at:

<http://www.microsoft.com/com/dcom/dcom95/eula.asp>

MDAC: Microsoft Data Access Components (MDAC) is required by NCSNAP to transmit data to the database server. Its licensing agreement can be found on the following site:

<http://www.microsoft.com/data/eulamdac21.htm>

The NCSNAP program is created with Microsoft Access97®. It can be run either with Access97® or Access97® Runtime. Microsoft Access97® Runtime is a limited version of Access97® which can be redistributed with an Access97® database application software product, such as NCSNAP. The NCSNAP Setup program installs Access97® Runtime on the computer. For further details about the End User Licensing, please see the following page on the Microsoft web site:

<http://msdn.microsoft.com/xml/IE4/License.asp>

Chapter 5

Other Systems and Responsibilities

I. The *NC-SNAP* will be administered for each individual in, or on the waiting list for, the state's Developmental Disabilities Service System:

- When an individual enters the DD Service System
- Annually
- Whenever there is a significant change in the individual's need profile

II. Administration of the *NC-SNAP*: The job classification primarily responsible for the administration of the *NC-SNAP* is the Case Manager. These individuals are typically familiar with persons served by the area programs' DD service system, while also serving as an advocate for the individual. There are situations, however, where the person does not have an assigned case manager. In these cases it is most likely that a knowledgeable QMRP/QDDP will need to administer the instrument. In any event, staff in the following categories must be trained and certified as examiners for the *NC-SNAP*:

- Case Manager (DD, Thomas S., "Responsible Therapist," etc.)
- Case Manager Supervisor
- DD Coordinator
- Regional DD Coordinator
- Single Portal Coordinator
- ICF/MR QMRP/QDDP (required when there is no independent case manager)

III. Training Responsibilities:

A. Training the Trainers: The NC-SNAP Researchers from Murdoch Center will train MRC Outreach and Staff Development staff to teach and certify examiners, and use the statewide database program. They will also provide the following:

- Training videotapes
- Examiner's Guides
- Instructor's Manuals, including instructions for the class and for data entry procedures
- Database Software for statewide data collection
- Sampling of training classes
- Sampling of area programs', MRC Staff Development programs', MRC Outreach programs' database/record systems
- Database maintenance
- Regular reports and custom reports upon request
- Troubleshooting and quality assurance

B. The DD Section will be responsible for:

- Storage and dissemination of NC-SNAP forms, Data Entry Worksheets, and Examiner Guides to MRCs and area programs.
- Database program support
- Quality assurance
- Oversight of compliance, protocols, procedures

- C. The MRC Staff Development Departments will train all QMRPs at the MRC. They will also maintain the MRC certification databases
- D. The MRC Outreach Departments will train all Case Managers, DD Coordinators, Single Portal Coordinators, Regional Coordinators, and QDDPs in their region. [Note: The Area Program will be responsible for identifying those individuals requiring training, and getting them registered and to the training classes] They will also maintain the Community certification database. Additionally, they will train at least one person from each area program to use the statewide database program.
- E. The Area Program Director will identify those who require training, register them for classes, and ensure they attend. (This includes one person for database program training.)
- F. Initial Timelines: Immediately following certification, Examiners should begin using the NC-SNAP.
Priorities for assessment:
- Persons entering the DD service system (ongoing, effective immediately)
 - DD Waiting List (should be completed by 5/31/00 for those currently receiving no services)
 - All others currently receiving services (prior to annual planning meeting)

III. Materials Needed for Class:

Examiners' Class:

- A sufficient supply of NC-SNAP forms
- A sufficient supply of Data Entry Coversheets
- A sufficient supply of each Sample Case History (#1, #2, and #3)
- One *Examiner's Guide* for each student
- At least one *Instructor's Manual*
- The training video
- A good quality television and VCR.
- *Optional:* Pre-printed "Class Preparation Form Report"

Data Entry Class:

- A suitable computer (laptop may be easiest)
- For a group, a data projector may be helpful
- The *NC-SNAP Statewide Database Program CD*
- Instructions for the database program (Chapter 4)

IV. Other: For questions, comments, suggestions, or problems, please contact one of the following NC-SNAP Researchers:

Aleck Myers 919-575-7742
 aleck.myers@ncmail.net

Rod Realon 919-575-7913
 rod.realon@ncmail.net

Tom Thompson 919-575-7913
 tom.thompson@ncmail.net

- V. Instructions for Database Coversheet: Once you have completed a *NC-SNAP* assessment you will need to complete the Database Coversheet. This should only take you a few minutes. However, *you must record all of this information so that the data entry person can enter the NC-SNAP profile into the computer.* There is only one entry on this form that is optional: *Consumer Case #* (this does not apply to everybody). All other information must be completed.

Note that for the question "Are there significant natural supports in place?" 'significant' refers to natural supports that if no longer available would still have to be provided. E.g., if an individual lives at home with his or her parents, and the parents became incapacitated, would new supports be a necessity? If yes, circle "yes" on the coversheet. A reduced copy of a completed coversheet is included in this chapter. Note that this coversheet may be updated from time to time.

Individual's Unique ID No.: If unknown, this may be created by listing the first three letters of the person's last name, then the person's first initial, and then a six-digit number representing the person's birth date (2 digits for month, 2 digits for day, 2 digits for year). E.g., Tom Miller, born March 6, 1963 = MILT030663. If more than one person has an identical ID, the program will prompt the addition of a letter at the end of the ID (e.g., MILT030663A for Tom's twin sister Teri).

North Carolina
Support Needs Assessment Profile
(NC-SNAP)

Database Coversheet

When administering the NC-SNAP, complete all sections of this form. Please print neatly! When finished, staple this form to the NC-SNAP and then turn it in to your designated data-entry person.

Individual's Name: Miller, Tom Social Security No.: 234-56-7890
Individual's Unique ID No.: ML T030663 Individual's Case #: 467890
Examiner's Name: Aleck Myers NC-SNAP Certification No.: 99YK9910
Area Program: VGFW Is Area Program a provider of services? Yes ☒ No
County: Granville Are there significant natural supports in place? Yes ☒ No

Individual's Type of Residential Placement: (Check only one)

- | | |
|---|--|
| <input type="checkbox"/> Independent Living | Group Home: |
| <input checked="" type="checkbox"/> Family Home | <input type="checkbox"/> DDA |
| <input type="checkbox"/> Foster Home | <input type="checkbox"/> ICF (Specify: |
| <input type="checkbox"/> Nursing/Rest Home | <input type="checkbox"/> State |
| <input type="checkbox"/> Skilled Nursing Home | <input type="checkbox"/> RHA |
| Supervised Living: | <input type="checkbox"/> VOCA |
| <input type="checkbox"/> EduCare | <input type="checkbox"/> EduCare |
| <input type="checkbox"/> RHA | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other (Specify: _____) | (Specify: _____) |
| Alternative Family Living: | <input type="checkbox"/> MRBD |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Other (Specify: _____) |
| <input type="checkbox"/> Other | Mental Retardation Center: |
| <input type="checkbox"/> Other Resid. Placement | <input type="checkbox"/> Black Mountain Center |
| (Specify: _____) | <input type="checkbox"/> Caswell Center |
| | <input type="checkbox"/> Murdoch Center |
| | <input type="checkbox"/> O'Berry Center |
| | <input type="checkbox"/> Western Carolina Center |

Current DD System Support: (Check only one)

- ☐ This is first contact
☒ Waiting list (no services)
☐ Waiting list (insufficient supports)
☐ Just entering system (supports started)
☐ Services est. & ongoing: (mark all that apply):
- | | |
|-----------------------------------|--------------------------------|
| <input type="checkbox"/> CAP | <input type="checkbox"/> TBI |
| <input type="checkbox"/> TANF | <input type="checkbox"/> CBI |
| <input type="checkbox"/> State | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medicaid | |

Chapter 6

"Look Behind" Quality Assurance

Occasionally, Certified Examiners will be asked to re-administer an *NC-SNAP* for an individual who was recently assessed by another examiner. This is part of the quality assurance process in place to monitor the *NC-SNAP*. Although some of the same records and sources will be used in both administrations, the re-administration should be approached openly without regard to previous scores.

I. Re-Administration Responsibilities

- A. *NC-SNAP* Researchers will identify individuals from the database for re-administration.
- B. The community area program will re-administer the *NC-SNAP* for:
 - 1. Five percent of the MRC residents
 - 2. Five percent of the community-based individuals whose previous *NC-SNAP* was administered by a certified examiner who is involved in the provision of services.
- C. MRC Outreach staff will administer the *NC-SNAP* for five percent of persons in community-based supports, with an emphasis placed on those who were previously assessed by a case manager from an area program that is a service provider.

D. The *NC-SNAP* Researchers will re-administer approximately one percent of all *NC-SNAP* assessments statewide.

II. Re-administration procedures: The responsible party (i.e., area program or MRC Outreach program) will be contacted by the *NC-SNAP* authors.

A. Monthly, the MRC Outreach Director will be provided a list of individuals for whom the *NC-SNAP* should be re-administered. The Outreach Director will delegate these to certified outreach examiners. Once assigned, the responsible person should contact the community area program case manager (who completed the first *NC-SNAP*) to determine who would be the best person to contact for an independent re-administration. Preferred contacts are (in order of preference):

1. Individual, parent, guardian
2. Non-employee of agency (area program or MRC) that conducted the previous *NC-SNAP* (for example, contract professional, day program employee, etc.)
3. Other employee (of agency that conducted the previous *NC-SNAP*)

B. Monthly, the Area Program DD Coordinator will be provided a list of people for whom the *NC-SNAP* should be re-administered. The DD Coordinator will then contact the QMRP or provider (QDDP) who administered the first *NC-SNAP* to determine who would be the best person to contact for an independent re-administration. Preferred contacts are the same as noted above.

C. Guidelines for readministering an *NC-SNAP* by phone: The following steps are provided as general instructions on how to conduct a phone interview to complete an *NC-SNAP* readministration. The examiner should feel free to use his or her "own style" of conversation.

1. When calling the contact person you plan to interview, begin by introducing yourself as a certified *NC-SNAP* examiner, and be prepared to offer your certification number and explain the purpose of the *NC-SNAP*. Explain your role in the process and where you work. Refer to the examiner who recently administered the *NC-SNAP* (you've probably recently talked to this examiner in order to get the contact person's name and number; hopefully that examiner also called the contact person to tell them you would call).
2. If the contact person expresses reluctance to participate, don't press the issue. Thank them for their time and re-contact the original examiner to identify another contact.

3. In obtaining information needed to complete the *NC-SNAP* it is usually best to begin by asking general questions, saving specific questions for later if some areas aren't answered. Do not read the items from the *NC-SNAP* and ask the contact person to make a choice. Instead, ask for general information such as:

"Tell me about how _____ cares for him/herself."

"Does _____ require someone to help care for him/her?"

"What kind of health services does _____ need?"

"Does _____ have any behavior concerns?"

After obtaining general information, ask more specific questions about unanswered items, such as:

"Does _____ require nighttime supervision?"

"Can _____ stay by him/herself?"

"If so, when and for how long?"

"How many times in the past year did _____ need to visit a physician?"

"How often does someone need to repair or maintain _____'s wheelchair?"

Continue to ask increasingly specific questions until you have all of the information needed to complete the *NC-SNAP*. If you cannot obtain sufficient information to score a particular item, ask the contact person how you may acquire the information. If necessary, re-contact the original examiner to seek further assistance.

Don't forget to thank the contact person!

Chapter 7

Reliability and Validity of the *NC-SNAP*

During its development, the *NC-SNAP* was field-tested on two separate occasions. In 1997, an earlier version of the *NC-SNAP* was compared to two other assessment instruments to determine which of the three most accurately assessed level of intensity of need for North Carolina's citizens with developmental disabilities. In 1998, after being selected as North Carolina's most probable choice, the *NC-SNAP* underwent revision to maximize its effectiveness. Following this revision, the *NC-SNAP* was examined in a final field test in 1999 to ensure that its reliability and validity were sufficient to be confidently used as a statewide assessment tool.

This chapter presents a brief overview of the design and pertinent data gathered from these field tests. A more extensive report is in preparation for publication. Additionally, extensive data will be collected as the *NC-SNAP* is implemented statewide. As updated reports become available, this chapter may be expanded.

1997 Field Test

Design

In order to test if an assessment instrument could predict the level of intensity of support need, the authors selected participants who currently received good or ideal supports. We categorized the level of support intensity those participants received. Assessment instruments, if accurate, should predict

the level of supports being received by the participants. Therefore, the process had three steps:

1. Find individuals with developmental disabilities who were well served
2. Determine the participating individual's current support array level
3. Administer the three assessment instruments

1. Find individuals who were well served

Five area programs agreed to participate. In all, 2,332 persons receiving services and supports were identified. In order to determine whether each individual was well served, a five-point survey was administered to the individual (or guardian), his or her case manager, and his or her service provider. An individual was identified for participation when all three sources agreed he or she was receiving either good (better than adequate) or ideal services. Of the 2,332 people, 559 or 24 percent were identified as participants.

2. Determine the participating person's current support array level

Next, case managers were asked to identify the support array received by each person for whom they had responsibility. To do this, both residential and other types of supports were described. Using this information, each participant was independently assigned to one of five support array levels.

Three independent raters achieved an agreement level of 98% with regard to the assigned levels.

3. Administer the three assessment instruments

Training sessions were conducted in each area program and at three mental retardation centers. During these sessions, case managers (or Qualified Mental Retardation Professionals) were trained to complete the instruments for participants on their caseload. As an additional control procedure, an author or a research assistant interviewed a second person familiar with the participant to complete an inter-rater reliability assessment.

Results

A. Research Question 1: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays?

1. Percent Exact Match (between assessment result and assigned support array):

NC-SNAP: 30.4

2. Percent Match Within One Level

NC-SNAP: 68.7

B. Research Question 2: What is the inter-rater reliability of the *NC-SNAP*?

1. Percent Exact Match Inter-rater Agreement

NC-SNAP: 70.7

2. Percent Inter-rater Agreement Within One Level

NC-SNAP: 98.3

C. Other factors

1. Mean duration of the *NC-SNAP*: 15 minutes
(range: 2 - 45)
2. *NC-SNAP* performed best with individuals with high needs.
3. *NC-SNAP* tended to overestimate need.

1999 Field Test

Design

Following the first field test, the *NC-SNAP* was judged to be approximately equal, across all variables, in effectiveness to the next best alternative instrument. At that time, the authors of the *NC-SNAP* were asked by North Carolina's Developmental Disability Policy Advisory Work Group to conduct a comprehensive analysis of the instrument, using the field test data, with the goal of maximizing the validity and reliability of the *NC-SNAP* through careful revision. In brief, the *NC-SNAP* was modified by identifying items associated with errors in predictive validity, and then eliminating or modifying those items to enhance accuracy.

Following this analysis, the re-tooled *NC-SNAP* was field tested in one area program, using a stratified sample ($N = 100$). The design of this second field test was almost identical to the 1997 field test, with the exception that an additional analysis was conducted to identify errors in support array level determination. Results were analyzed based on both the original assigned support array and on a "corrected" support

array. That is, the support array was corrected if additional information was obtained indicating that the original support array had been determined using incomplete or erroneous information, or if a change in the individual's status had occurred since the support array was originally determined.

Results

1. Research Question 1: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays?
 - a. Percent Exact Match for original (no corrections) support array: 70.0
 - b. Percent Exact Match when support array corrected for known errors: 92.5
2. Research Question 2: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays at each Need Level (1 to 5)?

Percent Accuracy by Level		
Level	Original (Uncorrected) Support Array	Corrected for Known Support Array Errors
1	46.2	76.9
2	33.3	91.7
3	76.2	90.5
4	85.7	95.2
5	92.3	100

3. Research Question 3: How well does the *NC-SNAP* predict current "good" or "ideal" support arrays for infants and children?

Percent Accuracy for Children	
Age Range	Corrected for Known Support Array Errors
Ages 0 - 2 years	100
Ages 2.01 - 6 years	100
Ages 6.01 - 16 years	100
Children Overall	100 (Corrected) 76.5 (Uncorrected)

Chapter 8

Answers to Frequently-Asked Questions

General Information about the *NC-SNAP*

➤ *How was the NC-SNAP developed?*

The NC-SNAP was developed through a 2-½ year research project with the aim of developing an easy-to-use, reliable and valid assessment tool. This was accomplished through an extensive comparative field test.

➤ *How was the NC-SNAP validated?*

The NC-SNAP was validated by determining its predictive qualities in an extensive field test. The NC-SNAP was administered to hundreds of persons who were receiving good to ideal services with support arrays that ranged from low (Level 1) to high (Level 5). The NC-SNAP predicted the level of need or support array a high percentage of the time.

➤ *How reliable is the NC-SNAP?*

Inter-rater reliability of the NC-SNAP was very good and compared favorably with standardized assessment instruments.

➤ *How will the NC-SNAP be used?*

The NC-SNAP will be used as the standard assessment tool for persons with developmental disabilities in North Carolina.

as part of the process to identify needs for support and as an initial step in the development of a support plan.

➤ *Will NC-SNAP results be used to determine what services are delivered to a client?*

No. The NC-SNAP does not specify services. It identifies needs, which can be met through a variety of services. Therefore, services will be neither added nor taken away solely on the basis of a NC-SNAP score.

➤ *Should the NC-SNAP be readministered each time the individual obtains a new or different service?*

No. Again, the NC-SNAP does not specify services. It identifies needs, which can be met through a variety of services.

➤ *When should the NC-SNAP be readministered?*

The NC-SNAP should be readministered at least annually or whenever there is a significant change in the individual's need profile (e.g., the individual suffers a debilitating stroke).

➤ *Will funding be tied to the NC-SNAP? If so, will funding be tied to individual budgets or will an Area Program be given funding to develop aggregate budgets?*

The NC-SNAP is not tied to funding on either an individual or aggregate basis. The issue of whether to do so and how to do so is, however, under consideration.

- *Must a case manager be a QDDP to become an examiner?*

Not necessarily, although this will usually be the case. There is no strict educational requirement to complete the NC-SNAP.

- *Do people living in DDA homes need a NC-SNAP?*

Yes. All persons with a diagnosis of developmental disabilities who are currently served under the North Carolina DD Service System (or on the waiting list for services) should have a NC-SNAP completed for them.

- *What about children in early intervention programs who do not have a formal diagnosis of developmental disability?*

In the absence of a formal diagnosis of developmental disability, children will receive a NC-SNAP only if there has been an application made on their behalf for CAP funding, they are receiving CAP funding, or they are receiving residential supports specifically designed for persons with developmental disabilities.

- *If an individual has no assigned case manager, who will be responsible for administering the NC-SNAP?*

The Area Program Director, or designee, is responsible for the identification of appropriate persons to assume this responsibility.

- *Will everyone on the DD Waiting List have a NC-SNAP administered?*

Yes. Those currently receiving no services will have a NC-SNAP completed by May 31, 2000. Those currently receiving services (i.e., but awaiting additional services) should have a NC-SNAP administered prior to their annual planning meeting (i.e., IEP, PCC, IPP, etc.)

- *If an individual is not receiving supports or services and has no case manager, who should serve as the examiner?*

Unless the individual is on the DD Waiting List, the NC-SNAP will not be administered to individuals not receiving supports or services from the North Carolina Service System.

- *Will examiners be issued a certificate card and certification number after successfully completing the training?*

Yes. They should receive their certification number at the completion of the training. After the training, a laminated certification card will be sent to them. It looks pretty cool!

- *What if someone fails the training?*

In order to be certified, students must meet the certification criteria. If someone can not successfully meet these criteria, he or she should repeat the training.

➤ *Will I need to be recertified as an examiner if I move to another part of the state?*

No. You may continue to use your original NC-SNAP Examiner number anywhere in North Carolina. Also, there is no plan to require recertification of examiners.

➤ *I'm a certified examiner. May I show my assistant how to administer the NC-SNAP and let her use my number?*

No. Only certified instructors may train and certify examiners.

➤ *How can I become an instructor?*

At this time, only Outreach and Staff Development staff from the Mental Retardation Centers can be trained to become instructors. They must be certified by the NC-SNAP researchers.

➤ *Will the NC-SNAP replace any other forms?*

Hopefully, yes. It is anticipated that the LOE and MR2 will be replaced. However, these forms should continue to be used until notification is received from the DD Section.

➤ *Can I make copies of the NC-SNAP?*

No. The NC-SNAP and all related materials (i.e., database software, instructional video, Instructor's Manual, Examiner's Guide) are copyrighted. However, these materials are available free of charge when used by the state of North Carolina in accordance to policy. Please contact one of the NC-SNAP authors if you need further clarification.

➤ *Where will the NC-SNAP be stored?*

Store the completed NC-SNAP in the individual's permanent record, in a centralized records location, or wherever official eligibility records are maintained.

➤ *Should I use a pencil or pen (blue or black ink) when I fill out the NC-SNAP?*

We recommend using a pen. Black ink is sometimes preferred or even required.

➤ *Where do we get blank forms when our supply runs low?*

Each of the MRCs have an established procedure to distribute NC-SNAP forms and related materials. Contact your regional MRC for further information. When the regional MRC's supplies run low, they should notify the DD Section in Raleigh.

➤ *Will a registration fee be charged for the Examiner's Training?*

No. The Mental Retardation Centers' Outreach Departments do not charge registration for required training.

Specifics about the NC-SNAP

- *Section I of the NC-SNAP asks whether the case has been reviewed by the Single Portal Coordinator. How do I know if this has occurred?*

The short answer is that if you don't know, answer "No." However, if any member of the InterAgency Council has reviewed the case, answer "yes" and write in their name.

- *Sometimes a person lives in one county but is from another county. Which county should be listed on the Data Cover Sheet (and entered into the database)?*

Enter the name of the "responsible" county (i.e., the county with formal responsibility for the individual).

- *How are the "cumulative scores" used?*

The cumulative domain scores and the cumulative raw scores are calculated for research purposes only at this time.

- *In the "Allied Health Professional" column of the "Health Care Supports" domain, the options are 'less than weekly' or 'weekly or more.' Does less than weekly mean the individual sees the professional less often (e.g., once a month)?*

Yes For some reason, this has been confusing to some examiners. When we reprint the NC-SNAP we will change the wording to 'less than once per week' and 'once a week or more often.'

- *How should an examiner score an item when there is conflicting information?*

Ultimately, the examiner should score the item based on his or her own judgment after reviewing all available information. If two sources disagree, the examiner should seek additional information (e.g., from other persons or evaluations, direct observation) to make an accurate decision.

- *Instructions for the NC-SNAP state that the examiner should assess the individual's 'need' as opposed to the services currently delivered. However, the "physician's services" column under "Health Care Supports" suggests that the examiner should average the number of physician visits during the previous year. Is this a contradiction?*

Not really, although we can see why this might seem unclear. When gauging the intensity of need associated with an individual's chronic health care need it is helpful to assess the frequency of required physician intervention. If, however, the examiner feels that the previous year's average does not accurately reflect the individual's most current needs (e.g., due to a very recent significant change in medical status), the score that best represents these most current needs should be marked.

- *Does "Equipment Supports" refer to the purchase of equipment?*

No. Score this item based on the amount of support that is required to maintain or service an individual's equipment. The purchase of the equipment should not be considered. For

instance, some communication devices are very costly to purchase. If the individual does not require frequent (i.e., less often than once per month) support to maintain the equipment, score Level 1.

➤ *What is the "Pre-printed Class Preparation Form Report?"*

This is a form that can be printed prior to an Examiner's Training Class. It can be found in the NC-SNAP Database Program, in the "Reports" folder. This can be very useful in organizing the class roster and assigning examiner numbers.

➤ *How is the NC-SNAP to be used as part of a personal plan for support?*

Page 4 of the NC-SNAP can be used as a worksheet for the development of a personal support plan.

➤ *Why doesn't the NC-SNAP include a category specifically for vocation (or communication)?*

Remember that the NC-SNAP is designed to functionally assess an individual's level of intensity of need. Some areas such as vocation and communication, while extremely important aspects of an individual's life, do not easily fit into need levels. During our field testing of the NC-SNAP we found that including a category for vocational support needs actually hurt the predictive validity of the instrument. We speculate that this is because of the wide range of supports needed at all levels.

Questions about the statewide database

- *What computer specifications are needed to use the database program?*

The program is written in *Microsoft Access*. Installation is done via a CD. Therefore, the computer must have a CD-Drive and *Microsoft Windows 95* or *98*. However, the computer does not require *Access* itself. Finally, there are three ways to download data to the statewide server. The preferred method is through SQL download, directly to the server via the internet. Another option is through an FTP file transfer. The final option, for those who do not have internet access, is to store the data on a diskette, and mail it to Raleigh.

- *Is the database program compatible with the Single Portal (Waiting List) program?*

The NC-SNAP database program was written for ease of use and is 'compatible' with both the Single Portal program and the Centralized Data Warehouse. However, this does not mean that they are the same. It is hoped that these will eventually be merged to eliminate or reduce the necessary data entry redundancy.

- *Is there a plan in place to modify the Data Entry Coversheet?*

Yes. We anticipate adding more information in the near future. Also, a redesign of the form is planned to facilitate data entry

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APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

Read attached instruction sheet before completing this application

Section 1

Sex: M ☐ or F ☐

Name _____
First Middle Last

Social Security Number _____ Medical Assistance Number _____

Date of Birth: _____ Phone #: (____) _____
month day year

Present Address _____
Street

City County State Zip Code

Section 2

Legal Representative/Guardian _____

Address _____

City County State Zip Code

Phone _____ Relationship to Applicant _____
(Ex: mother, father, friend)

Legal Rep./Guardian's Signature _____ Date _____

Section 3

Case Management Provider Name
and Address

Name _____

Address _____

City County State Zip Code Phone Number

Section 4



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DSM Diagnosis:

Axis I (Mental Health): _____

Axis II (Mental Retardation/Developmental Disability) : _____

Axis III (Physical Health): _____

Age Disability Identified: _____

Physician/SCL MRP Signature

Date

☐ SCL Waiver

CMHC MR/DD Director Signature

Date

☐ ICF/MR

Section 5

Applicant's Signature _____ Date _____

PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING.

6. MOBILITY

- ☐ Walks independently
- ☐ Walks with supportive devices
- ☐ Walks unaided with difficulty
- ☐ Uses wheelchair operated by self
- ☐ Uses wheelchair & needs help
- ☐ No mobility

Comments: _____

7. COMMUNICATION

- ☐ Speaks and can be understood
- ☐ Speaks and is difficult to understand
- ☐ Uses gestures
- ☐ Uses sign language
- ☐ Uses communication board or device
- ☐ Does not communicate

Comments: _____

8. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

- ☐ Requires less than 8 hours per day on average
- ☐ Requires 9-16 hours daily on average
- ☐ Requires 24 hours (does not require awake person overnight)
- ☐ Requires 24 hours with awake person overnight
- ☐ **Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

COMMENTS: _____

9. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS? (Choose only ONE box)

- ☐ **No assistance** needed in **most** self-help and daily living areas, and
Minimal assistance (use of verbal prompts or gestures as reminders) needed in **some** self-help and daily living areas, and
Minimal to complex assistance needed to complete complex skills such as financial planning and health planning.

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- ☐ **No assistance in some** self-help, daily living areas, and **Minimal assistance** for many skills, and **Complete assistance** (*caregiver completes all parts of task*) needed in **some** basic skills and all **complex** skills.

- ☐ **Partial** (*use of hands on guidance for part of task*) **to complete assistance** needed in **most** areas of self-help, daily living, and decision making, and Cannot complete **complex** skills.

- ☐ **Partial to complete assistance** is needed in **all areas** of self-help, daily living, decision making, and complex skills

- ☐ **Extreme Need:** All tasks must be done for the individual, with no participation from the individual

10. HOW OFTEN ARE DOCTOR VISITS NEEDED?

- ☐ For routine health care only / once per year
☐ 2-4 times per year for consultation or treatment for chronic health care need
☐ More than 4 times per year for consultation or treatment
☐ **Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

COMMENTS: _____

11. HOW OFTEN ARE NURSING SERVICES NEEDED?

- ☐ Not at all
☐ For routine health care only
☐ 1-3 times per month
☐ Weekly
☐ Daily
☐ **Extreme Need:** Several times daily or continuous availability

COMMENTS: _____

12. ARE THERE BEHAVIORAL PROBLEMS? Yes ☐ No ☐

IF YES-PLEASE CHECK ALL THAT APPLY.

- ☐ Self Injury
☐ Aggressive towards others
☐ Inappropriate sexual behavior
☐ Property destruction
☐ Life threatening (threat of death or severe injury to self or others)
☐ Takes prescribed medications for behavior control



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PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.

13. WHERE IS THE INDIVIDUAL CURRENTLY LIVING?

- | | | |
|--|--|---|
| <input type="checkbox"/> Living with family/relative | <input type="checkbox"/> Living in own home or apartment | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Group home or personal care home | <input type="checkbox"/> Nursing home | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> ICF/MR (Intermediate Care Facility) | <input type="checkbox"/> Living with a friend | <input type="checkbox"/> Other _____ |

14. DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Supported Living | <input type="checkbox"/> Medicaid EPSDT (if under 21) |
| <input type="checkbox"/> Medicaid Acquired Brain Injury | <input type="checkbox"/> Medicaid Home & Community Based Waiver |
| <input type="checkbox"/> Supported Employment | <input type="checkbox"/> Mental Health Counseling or Medication for a mental health condition |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> In home Support |
| <input type="checkbox"/> Other Medicaid Services | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Day Program | <input type="checkbox"/> Respite |
| <input type="checkbox"/> School | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Behavior Support | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Speech Therapy | |
| <input type="checkbox"/> Physical Therapy | |

15. WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?

- | | |
|---|---|
| <input type="checkbox"/> Day Program | <input type="checkbox"/> In home Support |
| <input type="checkbox"/> School | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Supported Employment |

16. THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):

- ☐ At home with a family member with someone to come in and help
☐ In the person's own home with minimal supports
☐ In a 24 hour staffed residence in the community
☐ In a 24 hour supervised family home in the community
☐ In a 24 hour staffed group home in the community
☐ In an ICF/MR

17. WHO IS THE PRIMARY CAREGIVER? (If staff, do not answer questions 18 & 19.)

- | | | | | | | |
|---------------------------------|----------------------------------|--------------------------------------|--------------------------------------|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Aunt | <input type="checkbox"/> Uncle | <input type="checkbox"/> Staff |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Brother | <input type="checkbox"/> Friend | <input type="checkbox"/> Neighbor | <input type="checkbox"/> Other: Who? _____ | | |

18. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Less than 30 years old | <input type="checkbox"/> 31-50 years old | <input type="checkbox"/> 51-60 years old | <input type="checkbox"/> 61-70 years old |
| <input type="checkbox"/> 71-80 years old | <input type="checkbox"/> Over 80 years old | | |

19. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

- ☐ Poor ☐ Stable ☐ Good ☐ Very Good



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Comments: _____

Person Completing Application: _____

Print Name

Relationship to Individual (if not individual)

Phone Number

Signature

Date

Additional Comments: _____

Mail to:
The Division of Mental Retardation
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621



SCL APPLICATION INSTRUCTIONS

Read these Instructions before completing the enclosed application

*** DO NOT LEAVE BLANK OR YOUR APPLICATION WILL BE RETURNED TO YOU AS INCOMPLETE**

Section 1

- *Name-** Please print first, middle and last name of applicant legibly
- *Sex-** Check M for male and F for female
- *SS#-** Should only have 9 numbers
- *Medical Assistance #-** This is the # on your MEDICAID card
- *DOB-** example: 08/18/1966
- Phone #-** Always include area code. If no phone, please indicate this
- *Present Address-** Please print legibly.

Section 2

Complete this section only if you are the **LEGAL** representative or guardian

If applicant is a minor there must be a legal guardian

If you complete this section you **MUST** sign your name in this section

Section 3

Complete this section if you currently have a case manager. This is someone who coordinates services. This could be a person or an agency such as the local comprehensive care center in your area. If you do not have a case manager leave blank.

Section 4

*This section **MUST** be completely filled out and signed by a Physician or a SCL MRP (mental retardation professional).

If applying for placement on the SCL waiting list, you **must** attach supporting documentation for the MR/DD diagnosis, this may be a psychological, report of school testing or any other reports that verify the diagnosis listed.

CMHC MR/DD Director Signature is **NOT** required unless you are applying for ICF/MR (facility) placement.

If applying for ICF/MR placement you **must** attach a copy of applicant's current Individual Support Plan, current Psychological, social history, crisis plan, behavior support plan, a current needs assessment, and minutes from the team meeting with a recommendation for ICF/MR admission. A MR/DD director's signature indicates that all community options have been exhausted and an ICF/MR is the least restrictive placement available.

* Axis I (if there is no diagnosis put "none")

* Axis II (if there is no diagnosis put "none")

* Axis III (if there is no diagnosis put "none")

* Axis IV (if there is no diagnosis put "none")

* Age disability identified-this is the age the applicant was diagnosed with mental retardation or a developmental disability (Ex: birth, 1 yr old, etc.) Mental Retardation must be present prior to age 18; Developmental Disabilities must be present prior to age 22.

Section 5

Applicant **MUST** sign this section if he/she does **NOT** have a legal guardian

If unable to sign, a mark or "X" is acceptable

*Questions 6, 7, 8, 9, 10, 11, 13, 16

Please check only **ONE** box that best describes the applicant

Person completing Application

***Name** of person completing this form

What is your **relationship** to the applicant?

Phone # of person completing this form

Signature and Date

MEDICAID WAIVER ASSESSMENT

SECTION I – MEMBER DEMOGRAPHICS

Name (<i>last, first, middle</i>)	Date of birth (<i>mo., day, yr.</i>) / /	Medicaid number
Street address	County code	Sex (<i>check one</i>) <input type="checkbox"/> Male <input type="checkbox"/> Female
		Marital status (<i>check one</i>) <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
City, state and zip code	Emergency contact (<i>name</i>)	Emergency contact (<i>phone #</i>) () -
Member phone number () -	Is member able to read and write <input type="checkbox"/> Yes <input type="checkbox"/> No	Member's height Member's weight

SECTION II – MEMBER WAIVER ELIGIBILITY

Type of program applied for (<i>check one</i>) <input type="checkbox"/> Home and Community Based Waiver <input type="checkbox"/> Model Waiver II <input type="checkbox"/> Acquired Brain Injury Waiver <input type="checkbox"/> Supports for Community Living Waiver <input type="checkbox"/> Consumer Directed Option <input type="checkbox"/> Blended	Adjudicated <input type="checkbox"/> / Nonadjudicated <input type="checkbox"/> Type of application (<i>check one</i>) <input type="checkbox"/> Certification <input type="checkbox"/> Re-certification <input type="checkbox"/> Re-application	
Member admitted from (<i>check one</i>) <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility <input type="checkbox"/> ICF/MR/DD <input type="checkbox"/> Other _____	Certification period (<i>enter dates below</i>) Begin date / / End date / / Certification number: _____	
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form <input type="checkbox"/> Yes <input type="checkbox"/> No	Has member been informed of the process to make a complaint <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>see instructions</i>)	
Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number () -
Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM)		
Enter all diagnoses including DSM or ICD-9 codes: AXIS I: (mental illness) AXIS II: (MR/DD) AXIS III: (Medical)	Is the member diagnosed with one of the following? <input type="checkbox"/> Mental Retardation/ IQ= (Date-of-onset / /) <input type="checkbox"/> Developmental Disability (Date-of-onset / /) <input type="checkbox"/> Mental Illness (Date-of-onset / /) <input type="checkbox"/> Brain Injury Cause of Brain Injury: Date of Brain Injury: / / Rancho Scale _____	

SECTION III – ASSESSMENT PROVIDER INFORMATION

Assessment/Reassessment provider name:	Provider number	Provider phone number () -
Street address	City, state and zip code	
Provider contact person		

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Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number
----------------------------------	------------------------

SECTION IV SELF ASSESSMENT

***For SCL and ABI waivers only**

***add additional pages as needed**

Community Inclusion (what do you like to do or where would you like to go in the community, where do you go for recreation, do you not get to go somewhere that you would like to)

Relationships (How do you stay in contact with your friends and family, do you need assistance in making or keeping friends, who are your friends)

Rights (do you understand your rights, are any of your rights restricted, do you know what is abuse or neglect)

Dignity and Respect (how are you treated by staff, do you have a place you can go to be with friends or to be alone or have privacy)

Health (who are your doctors, do you have any health concerns, what medicine do you take, how do they make you feel,)

Lifestyle (do you have a job, do you want to work, do you want to go to school, do you go to the bank, do you have spending money to carry)

Satisfaction with supports (are you satisfied with your services and supports, what do you like about them, what do you dislike about them, do you feel like you have choices about what you can do, are you happy with your life, what are you happy about, what are you unhappy about)

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Name (<i>last, first</i>)	Medicaid Number
SECTION V – ACTIVITIES OF DAILY LIVING	
1) Is member independent with dressing/undressing <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires hands-on assistance with upper body <input type="checkbox"/> Requires hands-on assistance with lower body <input type="checkbox"/> Requires total assistance	Comments:
2) Is member independent with grooming <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Requires supervision or verbal cues Requires hands-on assistance with <input type="checkbox"/> oral care <input type="checkbox"/> shaving <input type="checkbox"/> nail care <input type="checkbox"/> hair <input type="checkbox"/> Requires total assistance	Comments:
3) Is member independent with bed mobility <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Occasionally requires hands-on assistance <input type="checkbox"/> Always requires hands-on assistance <input type="checkbox"/> Bed-bound <input type="checkbox"/> Required bedrails	Comments:
4) Is member independent with bathing <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires hands-on assistance with upper body <input type="checkbox"/> Requires hands-on assistance with lower body <input type="checkbox"/> Requires Peri-Care <input type="checkbox"/> Requires total assistance	Comments:
5) Is member independent with toileting <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Occasionally requires hands-on assistance <input type="checkbox"/> Always requires hands-on assistance <input type="checkbox"/> Requires total assistance <input type="checkbox"/> Bowel and bladder regimen	Comments:
6) Is member independent with eating <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>) <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance cutting meat or arranging food <input type="checkbox"/> Partial/occasional help <input type="checkbox"/> Totally fed (by mouth) <input type="checkbox"/> Tube feeding (type and tube location)	Comments:

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Name (last, first)	Medicaid Number
7) Is member independent with ambulation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Dependent on device <input type="checkbox"/> Requires aid of one person <input type="checkbox"/> Requires aid of two people <input type="checkbox"/> History of falls (number of falls, and date of last fall)	Comments:
8) Is member independent with transferring <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Hands-on assistance of one person <input type="checkbox"/> Hands-on assistance of two people <input type="checkbox"/> Requires mechanical device <input type="checkbox"/> Bedfast	Comments:
SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
1) Is member able to prepare meals <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for meal preparation <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with meal preparation <input type="checkbox"/> Requires total meal preparation	Comments:
2) Is member able to shop independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for shopping to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with shopping <input type="checkbox"/> Unable to participate in shopping	Comments:
3) Is member able to perform light housekeeping <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for light housekeeping duties to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with light housekeeping <input type="checkbox"/> Unable to perform any light housekeeping	Comments:
4) Is member able to perform heavy housework <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for heavy housework to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with heavy housework <input type="checkbox"/> Unable to perform any heavy housework	Comments:

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Name (last, first)	Medicaid Number
5) Is member able to perform laundry tasks <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for laundry to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with laundry tasks <input type="checkbox"/> Unable to perform any laundry tasks	Comments:
6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of medication(s) <u>and</u> take them independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for medication to be obtained and taken correctly <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with obtaining and taking medication correctly <input type="checkbox"/> Unable to obtain medication and take correctly	Comments:
7) Is member able to handle finances independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for someone else to handle finances <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with handling finances <input type="checkbox"/> Unable to handle finances	Comments:
8) Is member able to use the telephone independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Requires adaptive device to use telephone <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance when using telephone <input type="checkbox"/> Unable to use telephone	Comments:
SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL	
1) Does member exhibit behavior problems <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check below all that apply and explain the frequency in comments)</i> <input type="checkbox"/> Disruptive behavior <input type="checkbox"/> Agitated behavior <input type="checkbox"/> Assaultive behavior <input type="checkbox"/> Self-injurious behavior <input type="checkbox"/> Self-neglecting behavior	Comments: Date of functional analysis: / / and/or Date of behavior support plan: / /

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Name (<i>last, first</i>)	Medicaid Number
2) Is member oriented to person, place, time <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Unresponsive <input type="checkbox"/> Impaired Judgment	Comments:
3) Has member experienced a major change or crisis within the past twelve months <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i>	Description:
4) Is the member actively participating in social and/or community activities <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i>	Description:
5) Is the member experiencing any of the following <i>(For each checked, explain the frequency and details in the comments section)</i> <input type="checkbox"/> Difficulty recognizing others <input type="checkbox"/> Loneliness <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Anxiousness <input type="checkbox"/> Irritability <input type="checkbox"/> Lack of interest <input type="checkbox"/> Short-term memory loss <input type="checkbox"/> Long-term memory loss <input type="checkbox"/> Hopelessness <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Medication abuse <input type="checkbox"/> Substance abuse <input type="checkbox"/> Alcohol Abuse	Comments:

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Name (<i>last, first</i>)	Medicaid Number
<p>6) Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)</p> <p><input type="checkbox"/> Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</p> <p><input type="checkbox"/> Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.</p> <p><input type="checkbox"/> Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.</p> <p><input type="checkbox"/> Required considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.</p> <p><input type="checkbox"/> Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</p>	Comments:
<p>7) When Confused (Reported or Observed):</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> In new or complex situations only</p> <p><input type="checkbox"/> On awakening or at night only</p> <p><input type="checkbox"/> During the day and evening, but not constantly</p> <p><input type="checkbox"/> Constantly</p> <p><input type="checkbox"/> NA (non-responsive)</p>	Comments:
<p>8) When Anxious (Reported or Observed):</p> <p><input type="checkbox"/> None of the time</p> <p><input type="checkbox"/> Less often than daily</p> <p><input type="checkbox"/> Daily, but not constantly</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> NA (non-responsive)</p>	Comments:
<p>9) Depressive Feelings (Reported or Observed):</p> <p><input type="checkbox"/> Depressed mood (e.g., feeling sad, tearful)</p> <p><input type="checkbox"/> Sense of failure or self-reproach</p> <p><input type="checkbox"/> Hopelessness</p> <p><input type="checkbox"/> Recurrent thoughts of death</p> <p><input type="checkbox"/> Thoughts of suicide</p> <p><input type="checkbox"/> None of the above feelings reported or observed</p>	Comments:

Commonwealth of Kentucky
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Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number
<p>10) Member Behaviors (Reported or Observed):</p> <p><input type="checkbox"/> Indecisiveness, lack of concentration</p> <p><input type="checkbox"/> Diminished interest in most activities</p> <p><input type="checkbox"/> Sleep disturbances</p> <p><input type="checkbox"/> Recent changes in appetite or weight</p> <p><input type="checkbox"/> Agitation</p> <p><input type="checkbox"/> Suicide attempt</p> <p><input type="checkbox"/> None of the above behaviors observed or reported</p>	<p>Comments:</p>
<p>11) Behaviors Demonstrated at Least Once a Week:</p> <p><input type="checkbox"/> Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required.</p> <p><input type="checkbox"/> Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions.</p> <p><input type="checkbox"/> Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.</p> <p><input type="checkbox"/> Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects).</p> <p><input type="checkbox"/> Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).</p> <p><input type="checkbox"/> Delusional, hallucinatory, or paranoid behavior.</p> <p><input type="checkbox"/> None of the above behaviors demonstrated.</p>	<p>Comments:</p>
<p>12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.:</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Less than once a month</p> <p><input type="checkbox"/> Once a month</p> <p><input type="checkbox"/> Several times each month</p> <p><input type="checkbox"/> Several times a week</p> <p><input type="checkbox"/> At least daily</p>	

Commonwealth of Kentucky
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Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number
13) Mental Status: <input type="checkbox"/> Oriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Depressed <input type="checkbox"/> Disoriented <input type="checkbox"/> Lethargic <input type="checkbox"/> Agitated <input type="checkbox"/> Other <hr style="width: 50%; margin-left: 0;"/> <hr style="width: 50%; margin-left: 0;"/>	Comments:
14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? <input type="checkbox"/> No <input type="checkbox"/> Yes	Comments:
SECTION VIII-CLINICAL INFORMATION	
1) Is member's vision adequate (<i>with or without glasses</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Difficulty seeing print <input type="checkbox"/> Difficulty seeing objects <input type="checkbox"/> No useful vision	Comments:
2) Is member's hearing adequate (<i>with or without hearing aid</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <i>(If no, check below all that apply, and comment)</i> <input type="checkbox"/> Difficulty with conversation level <input type="checkbox"/> Only hears loud sounds <input type="checkbox"/> No useful hearing	Comments:
3) Is member able to communicate needs <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Speaks with difficulty but can be understood <input type="checkbox"/> Uses sign language and/or gestures/communication device <input type="checkbox"/> Inappropriate context <input type="checkbox"/> Unable to communicate	Comments:

Commonwealth of Kentucky
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Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number
4) Does member maintain an adequate diet <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check all that apply and comment</i>) <input type="checkbox"/> Uses dietary supplements <input type="checkbox"/> Requires special diet (low salt, low fat, etc.) <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Forgets to eat <input type="checkbox"/> Tube feeding required (<i>Explain the brand, amount, and frequency in the comments section</i>) <input type="checkbox"/> Other dietary considerations (<i>PICA, Prader-Willie, etc.</i>)	Comments:
5) Does member require respiratory care and/or equipment <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>) <input type="checkbox"/> Oxygen therapy (Liters per minute and delivery device) <input type="checkbox"/> Nebulizer (Breathing treatments) <input type="checkbox"/> Management of respiratory infection <input type="checkbox"/> Nasopharyngeal airway <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Aspiration precautions <input type="checkbox"/> Suctioning <input type="checkbox"/> Pulse oximetry <input type="checkbox"/> Ventilator (list settings)	Comments:
6) Does member have history of a stroke(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>) <input type="checkbox"/> Residual physical injury(ies) <input type="checkbox"/> Swallowing impairments <input type="checkbox"/> Functional limitations (Number of limbs affected)	Comments:
7) Does member's skin require additional, specialized care <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> Requires additional ointments/lotions <input type="checkbox"/> Requires simple dressing changes (i.e. band-aids, occlusive dressings) <input type="checkbox"/> Requires complex dressing changes (i.e. sterile dressing) <input type="checkbox"/> Wounds requiring "packing" and/or measurements <input type="checkbox"/> Contagious skin infections <input type="checkbox"/> Ostomy care	Comments:
8) Does member require routine lab work <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, what type and how often</i>)	Comments:
9) Does member require specialized genital and/or urinary care <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> Management of reoccurring urinary tract infection <input type="checkbox"/> In-dwelling catheter <input type="checkbox"/> Bladder irrigation <input type="checkbox"/> In and out catheterization	Comments:

Commonwealth of Kentucky
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Department for Medicaid Services

Name (last, first)	Medicaid Number		
10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain in the comments section)	Comments:		
11) Does member have total or partial paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list limbs affected and comment)	Comments:		
12) Does member require assistance with changes in body position <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment) <input type="checkbox"/> To maintain proper body alignment <input type="checkbox"/> To manage pain <input type="checkbox"/> To prevent further deterioration of muscle/joints/skin	Comments:		
13) Does member require 24 hour caregiver <input type="checkbox"/> Yes <input type="checkbox"/> No			
14) Does member require respite services <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, how often)			
15) Does the member require intravenous fluids, intravenous medications or intravenous alimentation <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)			
<input type="checkbox"/> Peripheral IV Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
<input type="checkbox"/> Central line Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
16) Drug allergies (list)		17) Other allergies (list)	
17) Does the member use any medications <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list below) *add additional pages if needed			
Name of medication	Dosage/Frequency/Route		Administered by

Commonwealth of Kentucky

Department for Medicaid Services

Department for Medicaid Services

Name (*last, first*)**Medicaid Number**

Dosage/Frequency/Route

Administered by

18) Is any of the following adaptive equipment required (*If needs, explain in the comments*)

Comments:

☐Has ☐Needs ☐N/A

☐Has ☐Needs ☐N/A

☐ Has ☐ Needs ☐ N/A☐ Has ☐ Needs ☐ N/A☐ Has ☐ Needs ☐ N/A☐ Has ☐ Needs ☐ N/A☐ Has ☐ Needs ☐ N/A

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input type="checkbox"/> N/A

☐ Has ☐ Needs ☐ N/A☐ Has ☐ Needs ☐ N/A

<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A
<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A

<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A
<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A

<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A
<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A

<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A
<input type="checkbox"/>	Has	<input type="checkbox"/>	Needs	<input type="checkbox"/>	N/A

19) Please describe in detail any information regarding health, safety and welfare/crisis issues:

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number																																										
SECTION IX-ENVIRONMENT INFORMATION																																											
<p>1) Answer the following items relating to the member's physical environment (<i>Comment if necessary</i>)</p> <table style="width: 100%; border: none;"> <tr><td>Sound dwelling</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Adequate furnishings</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Indoor plumbing</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Running water</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Hot water</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Adequate heating/cooling</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Tub/shower</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Stove</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Refrigerator</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Microwave</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Telephone</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>TV/radio</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Washer/dryer</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Adequate lighting</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Adequate locks</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Adequate fire escape</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Smoke alarms</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Insect/rodent free</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Accessible</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Safe environment</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Trash management</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> </table>	Sound dwelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adequate furnishings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indoor plumbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Running water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hot water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adequate heating/cooling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tub/shower	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stove	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refrigerator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Microwave	<input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone	<input type="checkbox"/> Yes <input type="checkbox"/> No	TV/radio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Washer/dryer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adequate lighting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adequate locks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adequate fire escape	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke alarms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insect/rodent free	<input type="checkbox"/> Yes <input type="checkbox"/> No	Accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No	Safe environment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trash management	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Comments:</p>
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Trash management	<input type="checkbox"/> Yes <input type="checkbox"/> No																																										
<p>2) Provide an inventory of home adaptations <u>already present</u> in the member's dwelling. (<i>Such as wheelchair ramp, tub rails, etc.</i>)</p>																																											
SECTION X – HOUSEHOLD INFORMATION																																											
<p>1) Does the member live alone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, does the member receive any assistance from others <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain</i>)</p>	<p>Comments:</p>																																										

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (last, first)	Medicaid Number		
2) Household Members (Fill in household member info below)			
a) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
SECTION XI-ADDITIONAL SERVICES			
1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list below)			
a-Facility name		Facility address	
Reason for admission	Admission date / /		Discharge date / /
b-Facility name		Facility address	
Reason for admission	Admission date / /		Discharge date / /

Commonwealth of Kentucky
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Name (last, first)	Medicaid Number	
2) Does the member receive services from other agencies (Example: Both Waiver and Non-waiver Services.) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care and traditional Home health services covered by Medicare/Third party insurance)</i>		
a-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
c-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
SECTION XII-CONSUMER DIRECTED OPTION		
Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give reason:		
Has the member chosen Consumer Direction Option? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include form MAP 2000		
SECTION XIII-SIGNATURES		
Person(s) performing assessment or reassessment:		
Signature:	Title:	Date / /
Signature:	Title:	Date / /
Verbal Level of Care Confirmation:		
Date: / /	Time: am/pm	
Assessment/Reassessment forwarded to Support Broker/Case Management provider:		
Date Forwarded: / /	Time Forwarded: am/pm	
Name of Person Forwarding:	Title of Person Forwarding:	
Receipt of assessment/reassessment by Support Broker/case management provider:		
Date Received: / /	Time Received: am/pm	
Name of Person Logging Receipt:	Title of Person Logging Receipt:	
QIO Signature:		
Level of Care Date / /	Approval dates From: / / To: / /	

DEPARTMENT FOR COMMUNITY BASED SERVICES
NOTICE OF AVAILABILITY OF INCOME FOR LONGTERM CARE/WAIVER AGENCY/HOSPICE

MAID NUMBER: () INITIAL () CORRECTION
PROGRAM: COUNTY: () CHANGE () SPECIAL CIRCUMSTANCE
() SSN CHANGE () DISCHARGE
CLIENT'S NAME: BIRTH DATE:

PROVIDER NUMBER:
ADMISSION DATE: DISCHARGE DATE: DEATH DATE:
LEVEL OF CARE: LTC INELIGIBLE DATE:
FAMILY STATUS: SINGLE SPOUSE STATUS:
INCOME COMPUTATION

UNEARNED INCOME SOURCE	AMOUNT
RSDI	\$
SSI	\$
RR	\$
VA	\$
STATE SUPPLEMENTATION	\$
OTHER	\$
SUB-TOTAL UNEARNED INC.	\$

EARNED INCOME	AMOUNT
WAGES	\$
EARNED INCOME DEDUCTION	\$
SUB-TOTAL EARNED INC.	\$

TOTAL INCOME \$

DEDUCTIONS	AMOUNT
PERSONAL NEEDS ALLOWANCE	\$
INCREASE PNA	\$
SPOUSE/FAMILY MAINT.	\$
SMI	\$
HEALTH INSURANCE	\$
INCURRED MEDICAL EXPENSES	\$
TOTAL DEDUCTION	\$

THIRD PARTY PAYMENTS \$

AVAILABLE INCOME \$
AVAILABLE INCOME (ROUNDED) \$

AVAILABLE MONTHLY INCOME: \$

CASE STATUS
ACTIVE CASE: NO
IF ACTIVE, EFF. MA DATE:
IF DISC, EFF. MA DISC:

NOTIF. FORM: CONFIRMATION NOTICE
DATE PATIENT STATUS MET:

EFF. DATE OF CORR:
ENDING DATE OF CORR:

PRIVATE PAY PATIENT
FROM: THRU:

EFFECTIVE DATE:

WORKER CODE: CASELOAD CODE:

UPDATE DATE:

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

☐ Initial
☐ 30 Day
☐ Annual
☐ Modification

☐ SCL
☐ HCB
☐ ABI
☐ Model II

☐ Traditional
☐ CDO
☐ Blended (CDO/
Traditional)

PLAN OF CARE/ PRIOR AUTHORIZATION
FOR WAIVER SERVICES

Residential Status

☐ In Home
☐ Family Home Provider
☐ Adult Foster Care Provider
☐ Staffed Residence
☐ Group Home

1. MEMBER NAME: _____ Sex: ☐ MALE ☐ FEMALE
Last First MI
2. MAID NUMBER: _____ 3. DOB: _____
4. ADDRESS _____
Street City State Zip County
5. HOME PHONE () _____
6. CASE MANAGEMENT/SUPPORT BROKER AGENCY(CDO): _____ Phone: () _____
7. GUARDIAN NAME: _____ RELATIONSHIP: _____ Phone: () _____
8. POWER OF ATTORNEY:- _____ RELATIONSHIP: _____ Phone: () _____
9. REPRESENTATIVE NAME (CDO ONLY) _____ RELATIONSHIP: _____
10. ADDRESS: _____
Street City State Zip
11. PHONE: () _____
12. LEVEL OF CARE (LOC) CERTIFICATION NUMBER: _____
13. LOC CERTIFICATION DATES: _____ TO _____
14. PRIMARY CAREGIVER: _____ RELATIONSHIP: _____
15. ADDRESS: _____
Street City State Zip
16. PHONE: () _____



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Member Name: _____ MAID Number: _____

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Member Name: _____

MAID Number _____

Date Services Start: _____

Support Spending Plan

Traditional Wavier Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
						Total Cost per Month \$ _____

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column Dx4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
									Total Cost Per Month \$ _____

Commonwealth of Kentucky
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Department for Medicaid Services

Member Name: _____ MAID Number: _____

List each provider/employee name, address and telephone number:

Provider/Employee Name	Provider Number	Address	Phone Number

Clinical Summary: _____

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Member Name: _____ MAID Number: _____

Emergency Back-up Plan (CDO only)

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

Member/Guardian Signature: _____ Date: _____

Case Manager/Support Broker Signature: _____ Date: _____

Representative Signature (CDO): _____ Date: _____

Plan of Care/Support Spending Plan

Approved _____ **Denied** _____

QIO Signature/Title: _____ **Date:** _____

**LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM****I. ESTATE RECOVERY**

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

Signature

Date

**II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND
DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL
DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER**

- A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

Signature

Date

- B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

Signature

Date

- C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

Signature

Date

- D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

Signature

Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

Signature

Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

Signature

Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

Agency/Facility: _____

Address: _____

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME: _____ DOB: _____

MAID or MEMBER #: _____ DX: _____

Estimated Time Needed: Months _____ Indefinitely _____ Permanently _____
One Time Only _____

Procedure Code: _____ Date: _____

ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME: _____

PROVIDER NUMBER: _____

CASE MANAGER/SUPPORT BROKER: _____

TELEPHONE NUMBER: _____

AUTHORIZED DMS SIGNATURE: _____

DATE APPROVED: _____



INCIDENT REPORT

IDENTIFYING INFORMATION:

<input type="checkbox"/> ABI <input type="checkbox"/> SCL <input type="checkbox"/> SGF <input type="checkbox"/> DCBS	MAID/SS#: _____	Name: _____	
	DOB: _____	Reporting Agency: _____	Provider #: _____
	Reporting Person: _____	Title: _____	Phone: _____
	Case Management/Support Broker Provider: _____		Case Mgr /Support Broker: _____

INCIDENT INFORMATION:

<input type="checkbox"/> CLASS I	<input type="checkbox"/> CLASS II	<input type="checkbox"/> CLASS III	Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No
----------------------------------	-----------------------------------	------------------------------------	--

Date of ☐ Incident ☐ Discovery:

Time: AM/PM.

Location of incident: ☐ Day Program

☐ Residence ☐ Community ☐ Job Site☐ Respite ☐ Home Visit ☐ Transport Broker

Address: _____

Phone #: _____

Reported to:	NOTIFICATIONS		FINAL REPORT	
	Case Mgr./Sup. Broker: Class I and II-24 hrs/ lass III-8 hrs. Guardian: Class I -as directed / Class II and III- 24 hrs. Class III: DCBS-Immediate (if applicable) and DMR: 8 hrs.		Class II - 10 Days Class III - 7 days	
Case Mgr./Support Broker	Date: _____	Time: _____	Date: _____	
DMR	Date: _____	Time: _____	Date: _____	
Guardian/Individual	Date: _____	Time: _____	Date: _____	
DCBS	Date: _____	Time: _____	Date: _____	
Other:	Date: _____	Time: _____	Date: _____	

DESCRIPTION OF INCIDENT: (To be completed by staff witnessing or discovering the incident) Where did it happen? Who was involved? What happened? Action Taken? Attach other pages if necessary

[illegible]

Signature of Person Reporting: _____ Title: _____ Date: _____

CLASS II and III INCIDENT CODES: (check all that apply)

<input type="checkbox"/> A – Suspected Abuse	<input type="checkbox"/> H – Suicide Attempt	<input type="checkbox"/> O – Elopement
<input type="checkbox"/> B – Suspected Neglect	<input type="checkbox"/> I – Severe Behavior Outburst	<input type="checkbox"/> P – Emergency Room Visit
<input type="checkbox"/> C – Suspected Exploitation	<input type="checkbox"/> J – Property Damage	<input type="checkbox"/> Q – Hospitalization, Medical
<input type="checkbox"/> D – Death of an Individual	<input type="checkbox"/> K – Self Abuse	<input type="checkbox"/> R – Hospitalization, Psychiatric
<input type="checkbox"/> E – Emergency Chemical Restraint	<input type="checkbox"/> L – Individual Aggressed to Staff	<input type="checkbox"/> S – Medication Error
<input type="checkbox"/> F – Emergency Physical Restraint	<input type="checkbox"/> M – Peer on Peer Aggression	<input type="checkbox"/> T – Serious Injury
<input type="checkbox"/> G – Threatened Suicide	<input type="checkbox"/> N – Negative Media Attention	<input type="checkbox"/> U – Police Involvement
Other - _____		<input type="checkbox"/> V – CMHC Crisis Referral

DMHMR USE ONLY

DMHMR USE ONLY					
Need Identified			Follow-up Indicator		
<input type="checkbox"/> Lack of Staff	<input type="checkbox"/> Behavior Support	<input type="checkbox"/> (1) None	<input type="checkbox"/> (4) On-site Investigation		
<input type="checkbox"/> Staff Training	<input type="checkbox"/> Crisis Prevention	<input type="checkbox"/> (2) Telephone Follow-up	<input type="checkbox"/> (5) Technical Assistance		
<input type="checkbox"/> Supervision	<input type="checkbox"/> Co-occurring Disorders	<input type="checkbox"/> (3) Desk Level Inv.	<input type="checkbox"/> (6) Risk Review		
Appropriate use of police:		Appropriate use of Emergency Room:		Appropriate Follow-up:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

SUPERVISOR/CASE MANAGER/SUPPORT BROKER FOLLOW-UP

(Add additional pages if necessary)

MAID/SS# _____ Name: _____ Date of Incident: _____

I. Why did the incident occur? What staff action was effective in diffusing the incident or redirecting problem behavior? What staff action may have contributed to or aggravated the incident? Was treatment obtained in a timely fashion? Was a Behavior Plan followed? Was a Crisis Plan followed? Were they effective?

II. How could this incident have been prevented? How will the agency ensure that the incident does not occur again? What specific changes will be made in the person's life (home, work, day, etc.)? What will staff do differently? Does the person's team need to meet? What systems changes need to occur? How will management's role change?

III. What staff training needs were identified? On what date will the training occur? Who will provide the training?

IV. Are any changes necessary that will be made to the Individual Plan of Care, Crisis Prevention Plan, and/or the Behavior Support Plan? How will these changes support the person to achieve his/her vision and cope effectively? What other positive changes can be made to enhance the person's life? (such as, more choice, pursuing the person's vision, variety, developing relationships, developing and enhancing communications)

V. What is the individual's current status? What kind of impact has the incident had on the individual's life?

Submitted by: _____ Title: _____ Date: _____

Additional Signatures:

_____	Title: Case Mgr./Support Broker	Date: _____
_____	Title: _____	Date: _____
_____	Title: _____	Date: _____

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

TO: (1) _____ County Office
Department for Community Based Services

(2) Quality Improvement Organization (QIO)

(3) Department for Mental Health/Mental Retardation for SCL or
Department for Medicaid Services/Brain Injury Services Branch for ABI

FROM: (4) _____
Case Management Agency/Support Broker

DATE: (5) _____

A. SCL or ABI WAIVER PROGRAM ADMISSION

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Was admitted to the SCL or ABI Waiver Program on _____
(Circle SCL or ABI) (Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

(4) Primary Provider _____

(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

B. SCL or ABI WAIVER PROGRAM DISCHARGE

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Discharged from the SCL or ABI Program on _____
(Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

(4) Primary Provider _____

(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

C. SCL or ABI WAIVER PROGRAM TRANSFER

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Transferred on _____ from
(Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

(4) To Case Management Agency/Support Broker_____

(Phone Number) (Provider #) KY _____
(Address) (City) (Zip Code)

(5) From Primary Provider_____

(Phone) (Provider #) KY _____
(Address) (City) (Zip Code)

(6) To Primary Provider_____

(Phone) (Provider #) KY _____
(Address) (City) (Zip Code)

(7) To Hospital, Nursing Facility, or other facility_____

(Name of facility)

(Phone) (Provider #)
(Address) (City) (Zip Code)

PROCEDURAL INSTRUCTIONS FOR MAP-24C

Upon admittance/discharge/transfer of an individual in the Supports for Community Living Waiver or Acquired Brain Injury Waiver Program, the case manager/support broker shall forward a MAP-24C form to the local Department for Community Based Services Office in the county in which the member resides, the Quality Improvement Organization (QIO), the Department for Mental Health/Mental Retardation Services for the SCL waiver program or to the Department for Medicaid Services/Brain Injury Services Branch for the ABI waiver program. The case manager/support broker shall complete the form.

Use the following instructions to fill in the blanks on the MAP-24C:

INITIATION OF FORM

- Line One (1) Enter the name of the County of the Department for Community Based Services the form will be sent to.
- Line Two (2) Send the form to the Quality Improvement Organization
- Line Three (3) Send the form to the Department for Mental Health/Mental Retardation for the SCL waiver program or to the Department for Medicaid Services/Brain Injury Services Branch for the ABI waiver program.
- Line Four (4) Enter the name of the Case Management Agency/Support Broker filling out the form.
- Line Five (5) Enter the date the form was completed

A. FOR INITIAL ADMISSION TO THE SUPPORTS FOR COMMUNITY LIVING WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY WAIVER PROGRAM

- Line One (1) Enter the name, social security number, address and phone number of the member.
- Line Two (2) Enter the date the member entered the program.
- Line Three (3) Enter the name of the case management agency/support broker, phone number, and provider number.
- Line Four (4) Enter the name, phone number, and provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department of Aging and Independent Living will be the primary provider.

**B. FOR DISCHARGE FROM THE SUPPORTS FOR COMMUNITY LIVING
WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY WAIVER
PROGRAM**

- Line (1) Enter the name, social security number, address and phone number of the member.
- Line (2) Enter the date the discharge.
- Line (3) Enter the case management agency/support broker, phone number, provider number and address.
- Line (4) Enter the name, phone number, provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chose the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.

**C. FOR TRANSFER WITHIN THE SUPPORTS FOR COMMUNITY
LIVING WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY
WAIVER PROGRAM**

- Line (1) Enter the name, social security number, address and phone number of the member.
- Line (2) Enter the date the transfer took place.
- Line (3) Enter the previous case management agency/support broker, phone number, provider number and address.
- Line (4) Enter the new case management agency/support broker, phone number, provider number and address.
- Line (5) Enter the name, phone number, provider number of the current primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.
- Line (6) Enter the name, phone number, provider number of the new primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.
- Line (7) Enter the name, phone number, provider number and address of the facility that the waiver member has been transferred to on a temporary basis.

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

- ☐ SCL
☐ HCB
☐ ABI

Consumer's Name: _____ MAID #: _____

Case Manager/Support Broker: _____
Name Phone

Provider Number: _____

☐ Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my POC/SSP if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a Plan of Care (POC)/Support Spending Plan (SSP) to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws.
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins ____/____/____

Date traditional services end and CDO services begin: ____/____/____

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ MAID# _____

☐ Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

Representative Address: _____ Phone: _____

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

☐ Voluntary Termination of CDO Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

☐ Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:

- ☐ Health and Safety Concerns
- ☐ Exceeding Individual Budget
- ☐ Inappropriate Utilization of Funds
- ☐ Other (Describe)

Traditional Provider Agency _____

Traditional Provider Number _____

Consumer/Guardian Signature

Date

Representative Signature

Date

Case Manager/Support Broker Signature

Date

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

WAIVER SERVICES

TO: _____

AGENCY: _____

ADDRESS: _____

_____ **KY** _____ **PHONE:** () _____
(City) (Zip)

PHYSICIAN'S RECOMMENDATION

I recommend Wavier Services for:

MEMBER: _____

MAID NUMBER: _____

ADDRESS: _____

_____ **KY** _____ **PHONE** () _____
(City) (Zip)

DIAGNOSIS(ES): _____

Recommended Wavier Program: ☐ **HCBW (ARNP, PA or Physician signature)**
☐ **ABI**
☐ **SCL (SCL MRP or Physician signature)**

I certify that if Wavier Services were not available, institutional placement (nursing facility or Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disability [ICF/MR/DD]) shall be appropriate for this member in the near future.

PHYSICIAN or SCL MRP NAME: _____ **UPIN#:** _____

ADDRESS: _____

_____ **KY** _____ **PHONE** () _____
(City) (Zip)

_____ **SIGNATURE** _____ **DATE** _____



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

☐ HBCW
☐ SCL
☐ ABI

**Kentucky Consumer Directed Option
Employee/Provider Contract**

I (*employee name*) _____, have agreed to work
under the employment of (*employer name*) _____.

Duties under this contract will consist of the following:

Home and Community Supports:

- ☐ **Respite (*HCB, SCL, and ABI*)**
Total Approved Hours per month _____
- ☐ **Personal Care (*HCB and ABI*)**
Total Approved Hours per month _____
- ☐ **Homemaker (*HCB only*)**
Total Approved Hours per month _____
- ☐ **Attendant Care (*HCB only*)**
Total Approved Hours per month _____
- ☐ **Community Living Supports (*SCL only*)**
Total Approved Hours per month _____
- ☐ **Companion Services (*ABI only*)**
Total Approved Hours per month _____

Community Day Support Services:

- ☐ **Adult Day Training (*SCL only*)**
Total Approved Hours per month _____
- ☐ **Support Employment (*SCL only*)**
Total Approved Hours per month _____

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

I agree to provide the above listed services as required by my employer at the rate of \$_____ per hour. I will not exceed the total approved amount noted above.

I accept the check(s) as payment in full for the service(s) or items purchased. I will not make additional charges to or accept additional payments from the consumer(s).

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

I understand that DMS will not be liable for any injuries or losses incurred while providing services.

I understand that I may not be approved as a CDO provider if my background check detects that I have pled guilty to or been convicted of committing a sex crime or a violent crime.

I understand that I may not be approved as a CDO provider if my name is listed on the Kentucky Nurse Aid Abuse Registry.

For the Supports for Community Living (SCL) and Acquired Brain Injury (ABI) programs **only**, I understand that I may not be approved as a CDO provider if my name is listed on the Department for Community Based Services Division of Protection and Permanency's Central Registry.

I understand that I must maintain employee/employer confidentiality.

I understand this is an at-will contract and either party may terminate this agreement at any time.

I understand that I must notify my employer of the contraction of any infectious disease(s) and I shall abstain from work until the infectious disease can no longer be transmitted as documented by a medical professional.

I have received any and all training required by my employer in order to provide the necessary services as described in this contract.

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

I have received and fully understand the list of employment guidelines and will follow them to the best of my ability. I further understand that any or all items of this contract may be subject to renewal or change upon agreement by my employer and myself.

Employee/Provider	Date	Employer/Member	Date
-------------------	------	-----------------	------

Supports for Community Living Waiver

Medication Error Report (Part 1)

Instructions:	One copy of this report must be submitted each month by every provider supporting individuals. Do not include data for individuals receiving supports through state general funds. A separate report should be submitted for these individuals. This report should be addressed to: SCL Risk Management Team, Division of Mental Retardation, 100 Fair Oaks Drive, 4W-C, Frankfort, Kentucky 40621. The report should be postmarked by the 15 th of the month.
----------------------	---

For the month of : ,

Provider Name:

Provider Number:

Number of SCL
Individuals Supported:

Doses of medications planned
to be administered to SCL
individuals:

Total number of doses for
which there was a referenced
error:

Date the report
was submitted: / /



Supports for Community Living Waiver

Medication Error Report (Part 2)

Instructions:

This report must be submitted each month only for individuals for whom a dose or doses of medication were referenced as being administered in error. A separate sheet should be submitted for each individual. In the event that there are more than three medications with errors use additional sheets. Do not include data for individuals receiving supports through state general funds. A separate report should be submitted for these individuals. This report should be addressed to: SCL Risk Management Team, Division of Mental Retardation, 100 Fair Oaks Drive, 4W-C, Frankfort, Kentucky 40621. The report should be postmarked by the 15th of the month.

Provider Name: Provider Number: For the Month of: ,

Individual Name: Social Security #:

Medication	Date and Time of Error	Administration Site	Type of Error	Staff Member Responsible	Agency Follow-up
		<input type="checkbox"/> Residence <input type="checkbox"/> Day Program <input type="checkbox"/> Job Site <input type="checkbox"/> Community	<input type="checkbox"/> Respite <input type="checkbox"/> Home Visit <input type="checkbox"/> Other Wrong: <input type="checkbox"/> Time <input type="checkbox"/> Dose <input type="checkbox"/> Medication <input type="checkbox"/> Missed Dose <input type="checkbox"/> Other		
		<input type="checkbox"/> Residence <input type="checkbox"/> Day Program <input type="checkbox"/> Job Site <input type="checkbox"/> Community	<input type="checkbox"/> Respite <input type="checkbox"/> Home Visit <input type="checkbox"/> Other Wrong: <input type="checkbox"/> Time <input type="checkbox"/> Dose <input type="checkbox"/> Medication <input type="checkbox"/> Missed Dose <input type="checkbox"/> Other		
		<input type="checkbox"/> Residence <input type="checkbox"/> Day Program <input type="checkbox"/> Job Site <input type="checkbox"/> Community	<input type="checkbox"/> Respite <input type="checkbox"/> Home Visit <input type="checkbox"/> Other Wrong: <input type="checkbox"/> Time <input type="checkbox"/> Dose <input type="checkbox"/> Medication <input type="checkbox"/> Missed Dose <input type="checkbox"/> Other		

Total doses of medication which were referenced as being administered in error this month for this individual:

A

Total doses of medication planned to be administered to this individual this month:

B

Total doses planned divided by total doses referenced as being administered in error

A divided by B



**DIVISION OF MENTAL RETARDATION – SCL Screening and Training Requirements
October 2007 Edition**

Requirements for all newly hired staff and volunteers:

- ▶ TB screening completed in the past 12 months and received within 7 days of the date of hire or date of volunteer services;
- ▶ A criminal records check from the Kentucky Administrative Office of the Courts (AOC) completed prior to employment;
- ▶ A central registry check completed within 30 days of the date of hire; and
- ▶ A nurse aide abuse registry check completed prior to employment.

Training requirements for all staff:

Level I: Shadow another staff or family member/guardian/caregiver (at least 18 years old)

Level II: Independent functioning without ability to administer medications.

Must have following training prior to working alone:

- First Aid (excluding licensed or registered nurses)
- CPR
- Crisis Prevention and Management
- Identification and prevention of abuse, neglect, and exploitation
- Rights of individuals with disabilities
- Individualized instruction of the needs of the SCL recipient to whom the trainer provides supports

Level III: Independent functioning with ability to administer medication.

Must have the following training prior to working alone:

- Medication administration training per cabinet-approved curriculum
- Medications and seizures
- First Aid (excluding licensed or registered nurses)
- CPR
- Crisis Prevention and Management
- Identification and prevention of abuse, neglect, and exploitation
- Rights of individuals with disabilities
- Individualized instruction of the needs of the SCL recipient to whom the trainer provides supports

Core Training:

All employees must complete core training, consistent with a DMHMR-Approved curriculum, no later than 6 months from the date of employment

Training requirements for volunteers:

- ▶ Orientation to the agency
- ▶ First Aid (excluding licensed or registered nurses)
- ▶ CPR
- ▶ Individualized instruction of the needs of the SCL recipient to whom the trainer provides supports

DIVISION OF MENTAL RETARDATION – SCL Screening and Training Requirements October 2007 Edition

Case Management Training:

Effective August 1, 2007, all newly hired case managers must complete the DMR-approved Case Management training within the first 6 months of the date of hire or as soon as possible following the third month of hire if the case manager is unable to complete training within the first 6 months due to unavailability of the training.

Agency Trainer Qualifications

Training	Trainer Qualification
CPR/1 st Aid	As per current SCL Waiver
Medication Administration	Licensed medical professional
Medication & Seizures	Licensed medical professional
DMR Crisis Prevention and Intervention	<u><i>DMR Crisis Prevention and Intervention</i></u> Attend DMR Crisis Prevention and Intervention Training of Trainers H.S. Diploma with 2 years MR/DD experience or qualified as a SCL MRP.
<p style="text-align: center;">AND/OR</p> Crisis Management	<u><i>Crisis Management</i></u> Per qualifications of system utilized (MANDT, CPI, SCIP, NVCR, etc.) <i>Note: Crisis Management systems (not Crisis Prevention/De-escalation) to be determined by the agency. Any system teaching restraint should be utilized on an individualized basis, and should be taught as emergency safety procedure and only utilized as a last resort in the event of harm to self or harm to others.</i> <i>*If problems with crisis prevention/management are noted on certification review, completion of DMR Crisis Prevention and Intervention Curriculum may be required</i>
Abuse/Neglect Prevention	H.S. Diploma with 2 years MR/DD experience or qualified as a SCL MRP and completion of KRS 209 Training. Trainers to attend KRS 209 training every 2 years or if new information becomes available.
Rights of Persons with Disabilities	H.S. Diploma with 2 years MR/DD experience or qualified as a SCL MRP.
DMR Core Training	Attend DMR Core Training TOT H.S. Diploma with 2 years MR/DD experience or qualified as a SCL MRP.